India

Private Health Services for the Poor

Policy Note

May, 2004

SASHD
SASFP

Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
AP	Andhra Pradesh (Indian state)
BPL	Below Poverty Line
CHC	Community Health Center
DALY	Disability Adjusted Life Years
ESI	Employees State Insurance Scheme
GDP	Gross Domestic Product
GOI	Government of India
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
HPER	Health Public Expenditure Review
IMR	Infant Mortality Rate
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MTFP	Medium Term Fiscal Plan
NHA	National Health Accounts
NFP	Not-for-profit
OBA	Output Based Aid
PHC	Primary Health Center
PHSC	Punjab Health Systems Corporation
PRI	Panchayati Raj Institutions
RMP	Rural Medical Provider
SC/ST	Schedule Caste / Schedule Tribe
SHG	Self-Help Group
TB	Tuberculosis
UHC	Urban Health Center
UHIS	Universal Health Insurance Scheme
UP	Uttar Pradesh (Indian state)
WHO	World Health Organization

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The mission team would like to take this opportunity to thank the government officials in all four states visited as well as Delhi for their interest, cooperation and support throughout the study. They are mentioned by name in the individual state background papers that accompany this report. We hope that this policy note and the accompanying background papers will prove a valuable instrument to further the reform process across India with a view to securing improved health outcomes for India's poor.

India – Private Health Services for the Poor

Objective

Why are we doing this study?

Although India has made great strides since Independence, fertility, mortality and morbidity remain unacceptably high both compared to countries in the region and those at similar income levels. Almost a third of the Indian population live in poverty. The impact of poverty on health care and vice-versa is significant.

Achieving National Health Targets and the related Millennium Development Goals will entail addressing challenges to the existing health system.

Table 1 - The Millennium Development Goals and how they relate to India.

Millennium Development Goal	1990	2000	Goal 2015	Reduction remaining
Eradicate extreme poverty Population below poverty line (millions)	347	296	174	122
Reduce Infant mortality Infant mortality rate (per 1,000 live births)	80	69	27	61%
Improve maternal health Maternal mortality ratio (per 100,000 live births)[1]	>440	440	~110	75%
Combat diseases Incidence of tuberculosis (per 100,000 people)[4]	>185	185	<185	Disease halted & reduced

(Source: Millennium Development Goal Statistics and author's estimates)

While the root causes of poor health outcomes are poverty and low levels of education, government stewardship of the health sector bears some responsibility. Since independence, public financing and provision of health care services has been the main foundation of health care policy. Public sector health programs in India have faced well-recognized problems such as inadequate access by the most vulnerable groups, poor quality and coverage of primary and secondary facilities and until recently an excessive focus on sterilization and inadequate focus on maternal and child health.

The private sector has moved in to fill this gap. At Independence, the private sector accounted for just 8 percent of health care facilities. This figure had risen to 60 percent by the early 1990s. There is also mounting evidence that the private sector is providing an increasing share of primary health care and that large segments of the poor are using the private sector.

Until recently, governments have not explicitly recognized their responsibility for health policies outside the public sector. To date, private health care institutions in India have therefore grown in the absence of an explicit policy to define their role. This has raised questions regarding the quality and legality of care as well as the exploitation of the poor. Recently the Indian government has requested World Bank support in addressing these challenges. This study aims to present policy-makers with suggestions to address this situation.

[1] Modeled estimates, 1990 numbers assumed to be greater than 2000 estimate.

What questions will this study answer?

This study seeks to answer the following question:

Given the importance of the private health care financing and provision of services, how can the Government of India better utilize the private sector in health services delivery to the poor?

Within this broad framework, there are three policy questions of particular interest to the Government of India;

- **How to increase coverage for the poor?** especially for essential health care priorities. It is assumed that the most important health goals both for the Government of India (GOI) and from the perspective of the poor are those captured by the Millennium Development Goals.[2] Many states, especially the poorer ones, that have developed their own state health plans have indeed adopted these goals.

- **How to improve the quality of care for the poor?** A significant number of private health care providers in India (especially in the rural areas) are untrained practitioners. Although reliable data on their numbers are difficult to compile, it has been estimated that they number well over 1.25 million. The vast majority of these providers are not registered, qualified or regulated. There is evidence that the quality of care they provide is extremely low and can at times actually harm the health status of the patients. The supreme court has ruled their operations to be illegal and labeled them "quacks".[3] This highlights the need for a sensible government policy towards this sector.

- **How to reduce expenses for the poor?** Due to well-known asymmetries of information, the poor are especially vulnerable to exploitative charging practices. Without access to affordable health insurance, they face the largest health care bills as a proportion of their income. Moreover, they face the largest out of pocket expenses that can often lead them into an unsustainable spiral of indebtedness and increasing poverty. Given this situation, how should government respond?

What should be done? Within this broader context, this study seeks to provide some suggestions to policy-makers on these important questions. This paper presents high level information on the issues at a national level drawing on examples from various states in India.

How can it be done? While this paper points to what should be done, more in-depth case studies and manuals have been developed as background papers to this study. They present;

(i) State-level assessments of Andhra Pradesh, Bihar, Karnataka and Punjab. These states were selected to give an overview of poor, intermediate and richer states as well as to feed into current World Bank supported state health systems projects and other state-level initiatives.
(ii) Guides to contracting for primary health care and social franchising,
(iii) International case studies on the use of vouchers, health insurance and self-help groups. It is hoped that these background documents will provide interested policy-makers with concrete suggestions and a guide to how it can be done.

[2] Child mortality, maternal mortality and reproductive health, communicable diseases (especially Tuberculosis, Malaria, HIV/AIDs) and malnutrition.
[3] Peters et. al, Better Health Systems for India's Poor 2002. p156.

Table of Contents

Executive Summary

What's the problem?

Despite making great strides since Independence, fertility, mortality and morbidity remain unacceptably high in India. Although poverty and low levels of education are the root causes, poor stewardship over the health system bears some responsibility.

Although India's states exhibit a wide variation in health outcomes all but the best performing states need to focus on improving sexual and reproductive and child health care and reducing communicable diseases for the poor. The poor are disproportionately impacted by poor health care they have twice the rates of mortality, malnutrition and fertility of the rich.

What's the public sector doing about it?

The public sector's response is based on a system of public funding for publicly administered services run by state level governments. However, the public sector spends less than 1 percent of GDP (less than 3 percent of total spending) on health, one of the lowest rates in the world. For every $1 the public sector spends on health care for the poor, it spends $3 on the rich. Despite low levels of funding, the public sector has unrealistically high targets for coverage which results in resources being spread too thinly to be effectively utilized. As the majority of public health spending is state-financed, huge variations in state income and capacity levels result in huge differences in health outcomes while some states like Kerala and Tamil Nadu approach developed country standards others like Bihar and Uttar Pradesh have health indicators that are amongst the worst in the world.

The public sector also suffers from; a focus on inputs (fulfilling inappropriate standards and norms of service) rather than outputs or outcomes, weak and fragmented management, inadequate funding and little or no oversight over the whole sector. Primary public services are characterized by high absentee rates upto 67 percent in some states, high numbers of vacancies, poor quality of service and little responsiveness to the community. In turn this results in poor utilization and poor take-up of services. The PHCs account for less than 5 percent of deliveries in many states and provide full ante-natal care to less than a quarter of pregnant women.

What's the private sector doing about it?

The private sector has grown rapidly to fill this gap. Private spending now accounts for over 80 percent of health care spending one of the highest ratios in the world. Some surveys estimate that more than 90 percent of beds are in the private sector. The sector is dominated by unqualified, informal providers practicing in "quackery", representing a challenge to public sector regulatory and planning capacity. Although the NGO sector operates in an efficient and self-regulated manner it comprises a tiny fraction of health care services in India – less than 1 percent in most states. The formal for-profit sector covers a broad range of facilities from small clinics and nursing homes to large corporate chains of tertiary facilities.

The best private hospitals offer world class facilities that are able to attract an international clientele. Unfortunately the whole sector does not meet such standards. The private sector has grown in an unregulated manner and often offers overlapping facilities in which public doctors practice in their own time both legally and illegally. Problems that continue to plague the sector include, variable quality, unnecessary procedures, unqualified practitioners.

Can the private sector play a role in health financing?

The main source of health care financing is household out-of-pocket expenditure. Health insurance covers less than 10 percent of the population. The remainder are forced to rely on their own sources and family and friends to meet their expenses. Hospitalized Indians spend 60 percent of their annual income on medical care. Over 65 percent of the poor will borrow to meet their medical costs driving many of them into deeper poverty.

There is clearly an opportunity to grow a health insurance market with wide coverage and affordable premiums. The private sector is limited by current insurance legislation and focused on serving the richest segments of society. Government schemes launched in the past have not been financially viable or conceptually coherent and many have been subject to abuse. A successful future scheme should cover maternity, child health and catastrophic coverage. It could also involve private sector providers on an equal footing with public providers forcing the two sectors to compete. In order to establish such a viable scheme government will have to draw on successful international experience including using gate-keepers to reduce unnecessary care and examine best practice methods of controlling provider quality.

Can the private sector improve primary health care?

Despite the size of the private sector, much of preventive and promotive primary health care, especially for the poor remains in the public sector. Improving primary health care implies moving from an inflexible centrally controlled system to one where money follows the patient and services are delivered by the most efficient providers rather than public monopolies. This implies that government will have to formulate an effective strategy for the transition from an approach that is currently totally focused on service delivery to one in which government plays an effective stewardship role over the whole sector.

In a reformed health system the private sector can play the following roles;

- *Contracting out PHCs*: Although government is responsible for health care outcomes, it does not need to deliver all public health care through the public system. Governments must distinguish between public funded and public provided health care. In many cases it is more efficient to have government purchase health care from the private sector. India has several successful examples of contracting out PHCs in Andhra Pradesh and to a lesser extent in Karnataka. Both models illustrate what can achieved through the contracting model while both pilots have great room for improvement and potential scale-up.

- *Social Franchising*: Social franchising has the potential to improve the quality and accessibility of health care while maintaining costs at affordable levels. Branding health care products and services as any other franchise ensures brand quality and can capture economies of scale that would be beyond the reach of individual producers. Social franchising in Bihar has succeeded in transforming informal providers into a network of trained providers of family planning products. A second tier of clinics staffed by qualified OBGYNs has shown that qualified private doctors are willing to reduce item costs in return for increased volumes while maintaining acceptable standards and providing subsidized care for the poor.

- *Demand-led financing*: Although not currently practiced in India, voucher schemes are a potential way of increasing access for vulnerable groups. Vouchers could be used to provide the poor with access to services such as reproductive and child health through underutilized private facilities at set rates that could be lower than government rates and more effective.

This paper presents the above issues in an overall framework focused on *what to do* to improve health care for the poor. A series of background papers (and the annexes to this paper) provide answers and suggestions to the *how to* question.

I Introduction to the health characteristics of the poor

Who are the poor?

It is estimated that approximately 29 percent[4] of the Indian population live below the poverty line. This accounts for more than 290 million people, or nearly 25 percent of the world's poor population. Although India has made significant progress in reducing poverty, (down from an estimated 36 percent in 1993/4), there remains a considerable challenge. In order to meet the Millennium Development Goals, India will need to reduce the number of people in poverty by an additional 123 million people by 2015.

The poor are concentrated in the North of India in rural areas where they are predominantly engaged in agricultural activities. On average the poor have lower levels of education and suffer from higher disease prevalence. Women are typically more disadvantaged than men in socio-economic status. They are less literate and suffer from poor health care and a high rate of maternal mortality. The poor have worse access to health facilities and very low access to clean water and sanitation. Scheduled castes and tribes are over-represented in below the poverty line (BPL) households, over 65 percent of SC/ST households live below the poverty line.[5]

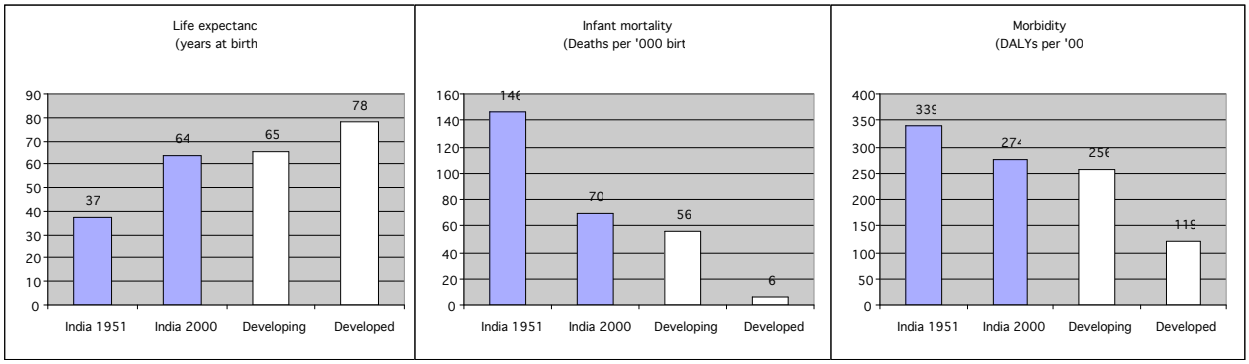
The impact of poverty on health care, and vice-versa, is significant. Studies have shown that the poor in India are disproportionately impacted by disease and have limited access to adequate medical services. High illiteracy rates, limited access to safe water and poor sanitation all contribute to the terrible state of health in which many of the poor live. Although India has made significant strides towards improving the overall health condition of the country's population there still remains a substantial unmet demand for basic health services.

What are the health characteristics of the poor?

National Health Status

India has made considerable progress in reducing fertility, mortality and morbidity since Independence. India's efforts to generate growth and reduce poverty have had been rewarded with tremendous improvements in key health outcome indicators.

Figure 1.1 : Health Improvements Since Independence



Source: ICRA Indian Health Care Industry 2003, and McKinsey: Health Care in India

[4] World Bank, "Country Assistance Strategy Progress Report", January 15th 2003.
[5] Annex 1 presents a fuller analysis of poverty in India for those not familiar with the country situation

However key health indicators remain unacceptably high both compared with countries in the region and those at similar income levels.

Table 1.1: Burden of Disease: disability-adjusted life years (DALYs) per thousand population lost to mortality and disability.

	DALYs per 1,000 population lost to			
Country/Region	**Mortality**	**Disability**	**Total**	**Percent of Total lost at Ages 0-4**
India	235	103	339	45
China	104	80	184	24
Other Asia	168	92	260	38
Middle East	209	91	300	50

Source: Murray and Lopez 1996 also quoted in World Bank, 1999.

Subnational Health Status

Within India, there are wide disparities in health status among states. A few states such as Kerala, Maharastra and Tamil Nadu are far above the country average and in certain cases, close to developed country averages, while others such as Bihar, Orissa and Uttar Pradesh lag far behind. High incomes and low poverty levels alone cannot secure the best health outcomes. Despite being the richest state and reducing poverty to just 6 percent , Punjab's health indicators are only a little better than national averages. This implies that the health system does make a difference and that different states will have to focus on different health priorities.

Table 1.2 : Key Health Indicators, India and Selected States

	Income (Rs per capita current 2001/02)	**Poverty** Headcount Ratio-(1999/00)	**IMR** (per 1,000)	**MMR** (per 100,000)	**Immunized** (% fully immunized)	**Malnutrition** (weight for age)
All India	20,198	26.1	67.6	453	53.3	45.5
Bihar	6,006	42.6	72.9	452	11.18	54.3
Orissa	11,093	47.2	90	367	44.0	54.1
Uttar Pradesh	12,038	33.0	82	707	44.0	51.7
Punjab	29,973	6.2	57.1	369	72.1	39.2
Marahastra	29,873	25.0	43.78	336	78.4	39.9
Kerala	26,603	12.7	16.3	87	79.7	21.9
Tamil Nadu	23,414	21.1	48.2	376	88.8	29.4
Karnataka	22.816	20.0	51.5	450	60.0	36.6
West Bengal	20,039	27.0	48.7	389	43.8	41.5
Andhra Pradesh	20,112	15.8	65.8	436	59.0	38.6

Source: State GNP and poverty count: World Bank Draft Punjab Economic Report; IMR, U5M, % children stunted: NFHS-2, 1998/99; MMR, The progress of Indian states, UNICEF, 1995.

Communicable diseases, maternity and nutrition are the major challenges

India's states are at different stages of the epidemiological and demographic transition. However, a burden of disease analysis indicates that all states still need to focus on Group I diseases. Group I diseases include pre-transition disorders such as communicable diseases, maternal, peri-natal and nutritional deficiency. Group II and III includes non-communicable diseases and injuries and accidents respectively. Table 1.3 below indicates the relative burden of disease caused by type of disease.

Table 1.3 : DALYs lost per thousand, by major cause groups in rural and urban areas

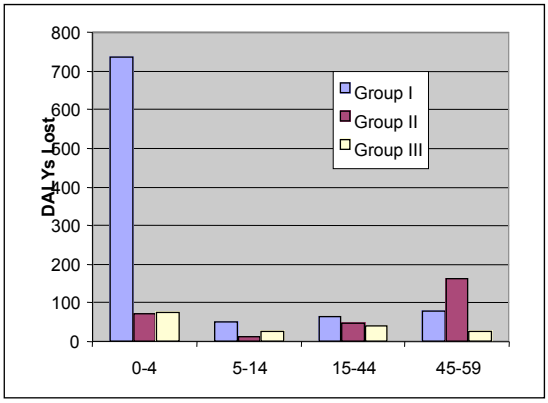
	DALYs lost per 1,000 Rural			DALYs lost per 1,000 Urban		
State	**Group I**	**Group II**	**Group III**	**Group I**	**Group II**	**Group III**
Andhra Pradesh	160.04	81.46	47.23	97.67	74.25	30.45
Punjab	134.41	73.51	43.86	114.39	56.15	32.08
Maharashtra	148.29	72.25	41.54	100.74	47.87	18.31
Karnataka	165.56	72.78	43.24	109.90	50.27	22.13
West Bengal	164.60	69.14	44.03	96.66	53.84	20.29

Source: ASCI 2001.

The need to improve maternal and child health care

The highest incidence of lost DALYs are in the 0-4 year category by infants succumbing to communicable diseases. Figure 1.2 presents data for AP but is representative of the whole country. This argues strongly for increased resource allocation to sexual, reproductive and child health care, immunization and improved nutrition. Future reforms and initiatives to strengthen the health care system must give priority to these areas and the primary sector in general.

Figure 1.2 : AP Distribution of DALYs lost by age group



Source: ASCI 2001.

India's Major Diseases

India has a disproportionately higher rate of acute respiratory infections and diarrheal disease per capita than the rest of the world (Table 1.4). Many diseases prevalent in India such as tuberculosis, diarrhea, and measles affect the poor more than the non poor, and they are preventable with inexpensive and simple interventions. In many states, perinatal mortality causes account for about 20 percent of Group I DALYs while maternity and related conditions account for 10 percent of Group I DALYs in the female

population. Tackling India's burden of disease will require a focus on primary health care and efforts to improve maternal and child health care, increase the proportion of children who are immunized and reduce communicable diseases, all areas that are targeted by the Millennium development goals. Improvements in these areas will require improvements in the current PHC system as well as strengthening of emergency obstetric care at the secondary and tertiary levels.

Table 1.4 - Top 10 Specific Causes of DALYs Lost in India, 1998

	India		
Causes of DALYs Lost	**Number of DALYs Lost**	**Percent**	**India's Percentage of the World**
Acute lower respiratory infections	24,806	9.2	30.1
Diarrheal disease	22,005	8.2	30.1
Ischemic heart disease	11,697	4.3	22.5
Falls (Injuries)	10,898	4.1	40.3
Unipolar major depression	9,679	3.6	16.6
Tuberculosis	7,577	2.8	26.9
Road traffic Injuries	7,204	2.7	18.5
Measles	6,474	2.4	21.4
Anemia	6,302	2.3	25.5
Fire related injuries	5,723	2.1	47.8
All causes	268,953	100.0	19.5
Population (thousands)	982,223	100.0	16.7

(Source: WHO, 1999)

Although HIV/AIDS infection rates on a per capita basis in India are below the world average, in some states (such as Andhra Pradesh and Karnataka) the disease has begun to spread beyond the high risk groups and into the general population. HIV/AIDS infections are concentrated primarily in the urban areas and are not yet a major health concern to the rural communities. HIV/AIDS education is however critical to prevent the spread of the disease into these communities. Studies have shown that HIV/AIDS awareness is very low amongst poor communities.

What are the implications for health service delivery?

The need to focus on primary health care

Given the situation described above, it is clear that the primary health care system will play the most important role in reducing the burden of disease through prevention, promotion and curative services as appropriate. It is important that the primary health care system functions efficiently, providing all children with all vaccines, providing all pregnant women with a full program of ante-natal care and location for safe institutional delivery and meet the demand for family planning services. The primary health care system should also provide a first port of call for the sick and an effective referral system. Within primary health care, governments should focus on sexual, reproductive and child health. A sound and functioning primary system would then need to be supported with improved emergency obstetric care available at the secondary and tertiary levels.

The need to focus on nutrition, sexual, reproductive and child health

Providing health care for the poor means focusing on areas that most strongly impact the poor. There is a wide divergence of coverage levels of the richest and poorest segments of society with respect to key interventions such as ante-natal care provision, contraceptive prevalence and institutional deliveries. The poorest quintile has fertility rates of 4.1 and the richest, fertility rates of 2.1[6]. Increased fertility only furthers the level of poverty due to the increased financial burdens that accompany larger family sizes.

Almost half the poor children in India are not immunized at all.[7] This stands in stark contrast to the wealthiest segment in which less than 8 percent of children were not immunized. The BIMARU region has the lowest rates of immunization in the country. Tuberculosis and Measles are among the top ten causes of DALY's lost in India, diseases that can be easily prevented provided that the adequate immunization is administered.

Table 1.5 - Comparison of Health Status of Children in India, by Quintile.

Condition	Poorest Quintile	2nd Quintile	3rd Quintile	4th Quintile	Wealthiest Quintile	Total
Malnutrition*	55.6	54.0	48.6	43.4	30.9	47.1
No Immunization	48.4	40.8	27.5	18.0	7.9	30.0
All Immunization	17.1	21.7	34.7	48.2	65.0	35.4

(Source: World Bank "Poverty in Uttar Pradesh" page 53)
**Stunting – Height for age.*

Almost half of Indian children suffer from some form of malnutrition and diseases and symptoms resulting from malnutrition, such as stunting and wasting are prevalent in the rural communities, especially in poorer areas. Malnutrition is a key risk factor for many childhood illnesses and the health status of the poorest women. Interventions to improve nutritional outcomes are vital to tackling the burden of disease and achieving the MDGs.

The need for public health surveillance

Given the high rate of communicable disease and the low rate of immunizations the health system will need to provider for a large number of people suffering from tuberculosis, ARI, measles, malaria, leprosy, and other common ailments as well as HIV/AIDs. This implies establishing an effective public health surveillance system, systematically collecting and analyzing timely and accurate health data and disseminating the results and developing action plans to combat disease. An effective system will also monitor the effectiveness of the disease control programs. As many infected patients approach private facilities first, it also implies forming close links and information sharing channels with the private sector and even informal providers (see later sections) especially to combat outbreaks of infectious diseases.[8] Such a system is currently non-existent in almost all states.

[6] World Bank Statistics – Poverty and Health.
[7] UP/Bihar Poverty Study, page 53
[8] For more practical information on this topic see "Public Health Surveillance Toolkit – A guide for busy task managers" Abreu et. Al. The World Bank February 2002.

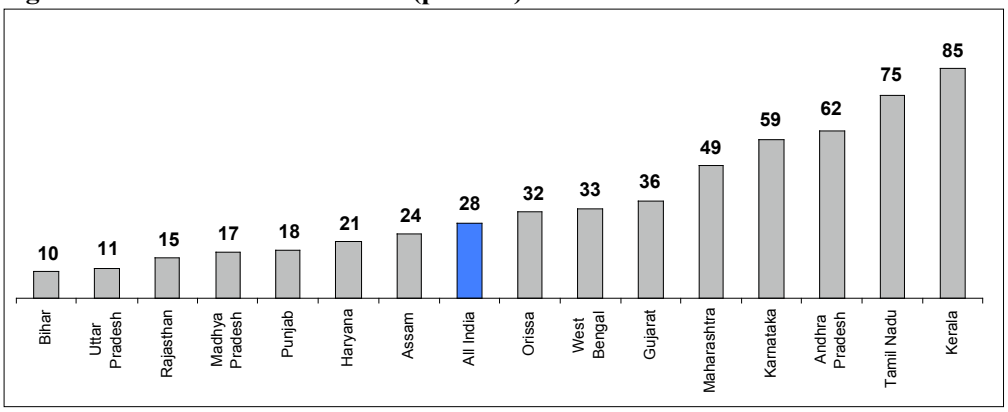
II Public Health Care for the Poor

Public Primary Health Care

India's primary health care system is based on the Primary Health Center (PHC) and its attached sub-centers. Each PHC is targeted to cover a population of 30,000 (or 20,000 in remote or rural areas). The PHCs are hubs for 5-6 sub-centers that each cover 3-4 villages and are operated by an Auxiliary Nurse Midwife (ANM). The PHCs act as referral centers for the Community Health Centers (CHCs), 30-bed hospitals and higher order public hospitals such as the Taluka or District level hospitals.[9]

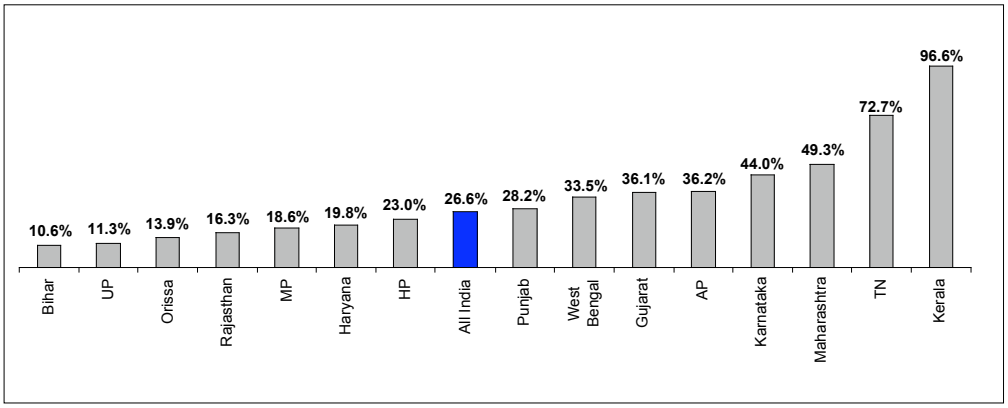
The PHC is charged with providing promotive, preventive, curative and rehabilitative care. This implies offering a wide range of services such as health education, promotion of nutrition, basic sanitation, the provision of mother and child family welfare services, immunization, disease control and appropriate treatment for illness and injury. Unfortunately, PHCs are not currently fulfilling all these functions, many of which have a strong public good component. (see below).

Figure 2.1 : Full Ante-natal Care (precent)



Source: NFHS- II 1998/9.

Figure 2.2 : Institutional Deliveries (per 1,000 births)



Source : The Poor and Health Service Use in India 2001.

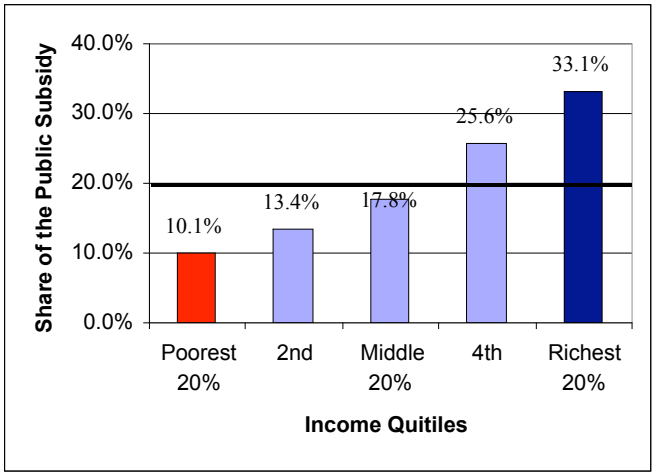
Although state governments around India are focused on reducing the IMR, MMR and communicable diseases, only in a few states, have public health systems been able to meet this challenge. Figures 2.1

[9] A fuller picture of the primary health care system is presented in Annex 2 using Karnataka as a case study.

and 2.2 illustrate that even with support from the private sector, less than half the children are fully immunized and less than a third of deliveries are institutional which, in turn, contributes to high levels of disease and maternal and infant mortality. As the figures illustrate, there is large variation between the states. Unfortunately the most populous states happen to be the poorest and are not able to reach even a quarter of the target population.

Moreover, the public sector is not good at reaching the poor and/or those in remote areas. A recent assessment of the public subsidy to the sector has shown that the poorest 20% of the population capture only 10% of the subsidy less than a third that captured by the richest 20% (see Figure 2.3).

Figure 2.3 : Distribution of public expenditures in India on curative care, by income quintile 1995-1996.



Source: National Council of Applied Economic Research, India 2000.

Empirical studies have also shown that the quality of primary public services provided by the public sector did not improve significantly between 1987 and 1996. Moreover, income, education and the overall quality of state administration are more important than specific public health interventions in explaining differences in demographic and health indicators during the period 1981-1991.

Reasons for poor public sector performance

Although there are a lot of reasons for poor public performance almost all of them stem from weak stewardship of the sector. Three basic issues are highlighted that together produce a poor incentive framework. Each area is discussed in detail below;

- A bureaucratic approach to health care provision,
- Lack of accountability and responsiveness to the general public and
- Incongruence between available funding and commitments.

A bureaucratic approach

State governments approach the provision of health care from a bureaucratic paradigm. This results in;

- **A rigid PHC structure**: that is the same for every area and therefore unable to respond effectively to local realities and needs. The PHCs exhibit very little differentiation despite

markedly different populations and circumstances. For instance the number of ANMs per PHC is the same throughout the country despite the fact that some states have twice the fertility level of others. Public health officials are focused on and limited by the requirement to fill sanctioned posts rather than responding to local needs. Moreover, political interference in the location of health facilities often results in an irrational distribution of PHCs and sub-centers.

- **A focus on inputs rather than outputs**: Government health departments are focused on implementing government norms, paying salaries, ensuring that minimum facilities are available rather than measuring health system performance or health outcomes. This results in a supply driven approach. For instance, despite being completely underutilized each PHC still has 6 beds.

- **Lack of public health management capacity.** In general, the public health care system is managed and overseen by the District Health Officers. Although they are qualified doctors, they have little or no training in public health management and are transferred frequently. Moreover, even if they had the training, they do not have the flexibility to reallocate financial, capital and human resources to achieve better outcomes. Strengthening the capacity for public health management at the District and Taluk level is crucial to improving public sector performance and nurturing partnerships with the private sector.

- **Many PHC posts are vacant for long periods.** A field visit to a PHC in Nelamangala Taluka (Karnataka) revealed a sanctioned post complement of 25 of which only 18 positions were filled. Budgetary figures indicate that on average PHCs in Karnataka have 25% of sanctioned posts unfilled. It is not clear whether this is a deliberate strategy to reduce the budgetary burden or simply a result of administrative inefficiencies. Moreover, when posts are filled doctors are often absent (see below).

Lack of accountability

The lack of accountability and responsiveness stems from the fact that there is no formal feedback mechanism and no tradition of and no incentive to treat citizens as clients. In every state visited, patients complain about rude or abrupt health workers that discriminate against women and minorities from schedule castes or tribes and the poor in general. Patients understand that the incentives within the public sector cannot stimulate performance, "anyhow they will get their money, so they don't pay much attention" says a patient in Andhra Pradesh.[10] As another patient remarks in Mumbai, "the same government doctor who was not easily or conveniently accessible, whose medication was not satisfactory and whose manner was brusque and indifferent transformed into a perfectly nice and capable doctor when he was seeing a patient in his private practice".[11] In general the lack of accountability results in;

- **Absentee doctors**: It is difficult for the public sector to attract qualified doctors to the rural areas. Although in theory, Medical Officers are required to be present at the practice, many medical officers visit the PHC infrequently, preferring to operate parallel private clinics in urban areas or operate private practices from their residences after hours. A recent study has estimated that country wide absenteeism rates in India are 43% in the public health sector.[12] When they are present their poor behavior discourages patients from approaching the PHC for health care.

- **Unresponsive ANMs.** In Karnataka dais attend as many deliveries as ANMs about 12 percent of total births. Villagers complain that ANMs are not available for deliveries at night, even if the

[10] Probe Qualitative Research, "Perceptions of public and private health care in Andhra Pradesh" 2003.
[11] Probe Qualitative Research, Mumbai 2003.
[12] Namzul Chaudhury et. al. "Teacher and Health Care Provider Absenteeism: A multi-country study". World Bank 2003.

mother was willing to come to the PHC. In addition, nearly a third of women who had planned to have an ANM assist at their deliveries finally had a dai or an experienced relative in attendance, since the ANM was either not available or unwilling to attend if women went into labor at night.

- **Inconvenient opening times:** PHCs are very underutilized by outpatients for the reasons outlined in this section. The situation with respect to inpatients is even worse, as PHCs have limited opening hours and there is no one available to attend to the patients in the evenings or during the weekends.

- **Informal payments:** Although not officially sanctioned, most PHCs require patients to make small informal payments prior to receiving treatment. Once the costs of transport and time taken to get to the PHC are factored in, this often makes the cost of public sector health care more expensive than low-cost private providers.

- **Little or no community participation**: The community are not involved in the operation of the PHC. Although in theory, the PHC is monitored by the Panchayati Raj system through a community health committee, in practice, villagers complain that they do not know which individuals are members of the community resulting in a situation in which the PHC is not responsive to local needs e.g. opening times, range of services and customer satisfaction.

Incongruent budgets and commitments

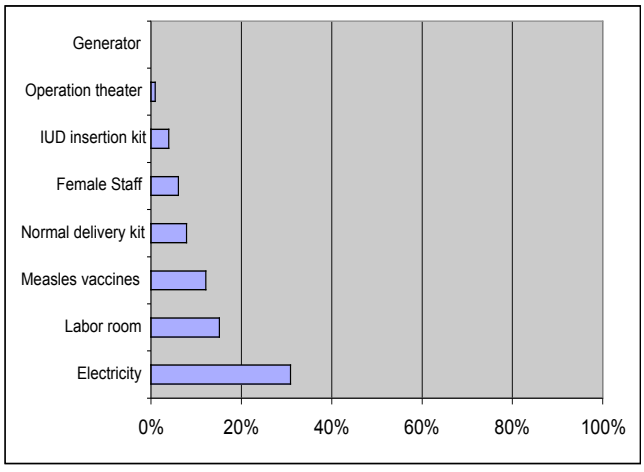
The lack of resources, which is some states is acute, is certainly a contributing factor to the poor performance of the primary health care system. In poor states spending levels are extremely low and yet expectations for coverage remain high. This incongruence is a key factor in explaining poor utilization of public spending. However, government officials are quick to blame inadequate budgetary provision for the breakdown in the system without examining how government could improve its efficiency within the current resource envelope. The incongruence between resources and targets results in;

- **Lack of medicines:** The current budget for essential drugs at the PHC at Rs75,000 per annum is inadequate to ensure that sufficient drugs are available at the PHC, especially if the PHC is staffed with dedicated health workers and able to attract a large number of patients.

- **Limited doctor salaries:** are an obstacle to attracting qualified doctors to the rural areas especially given the high costs that many students will pay for their medical training.

- **Poor condition of PHC infrastructure**: When government budgets are under extreme pressure the first area that is usually identified for cutbacks is the maintenance budget. PHCs across India are poorly maintained and supplied only sporadically with electricity. Vehicles quickly fall into disrepair as spares are not forthcoming and/or the process required to replace the simplest parts is so convoluted that even a flat tire can put a care out of action for over a year. This deters patients from seeking care there. Within such a context, it is important to focus on system reforms before considering any potential budget increases.

Figure 1.3 : Bihar equipment at PHCs (%)



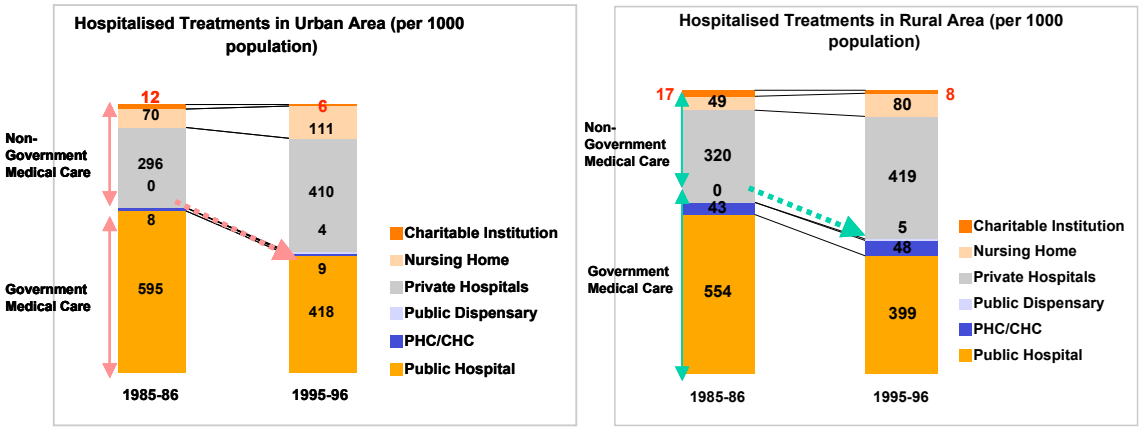
Source: National Family Health Survey II, 1998/9

III Private Health Care for the Poor

Growth of the private sector[13]

At independence less than 8% of all medical institutions in the country were maintained by wholly private agencies.[14] By the early 1990s this figure had reached close to 60% and there are indications that it increased even further during the last decade. In large part, the private sector has emerged in response to the current health care situation outlined above. The decade to 1996 witnessed a steep decline in the market share of public health services. The proportion of patients seeking ambulatory care in the public sector fell from 32% to 26% in rural areas and from 30% to 17% in urban areas. Similarly, by 1996, the private sector accounted for 54% of rural hospitalization and 70% of hospitalization in urban areas.[15] There is strong evidence that such official statistics grossly underestimate the size of the private sector which, through facility surveys in various states, has recently been estimated as high as 93 percent of all hospitals and 64 percent of all beds nationwide.[16] This remarkable growth in private sector health services has occurred largely by accident as the private sector has stepped in to meet needs that the public sector could not address.

Figure 3.1: The private sector captures increasing market share from the public sector



Source: India NFHS-2, 1998/99, NSS 52nd Round 1995/96 and KPMG 2003.

Structure of the private sector

The private sector is a broad group that includes for profit and not-for profit providers, NGOs, missionary hospitals, private pharmacies and blood banks and unqualified informal providers some of whom are registered and some are not. For the purposes of this study it is useful to divide private sector providers into three major groups, each of which is discussed in more detail below;

- Rural Medical Providers (RMPs);
- Not-for-profit sector including NGOs and religious-based facilities;
- Corporate or for-profit sector.

[13] For the purposes of this study, the private sector is defined as all non-governmental health care. This includes; NGOs, for profit and not-for-profit institutions, private clinics and nursing homes, informal rural medical practitioners (whether registered or not) and donor-funded project facilities.
[14] Bhore Committee report 1946.
[15] National Sample Survey 52nd round.
[16] World Bank, India Raising the Sights 2001.

Rural Medical Providers (RMPs)[17]

RMPs are unqualified medical practitioners. They operate on a for profit basis offering mainly curative services largely in the rural and semi-urban areas. The vast majority are male solo practitioners in out-patient settings. A Punjab study revealed that less than 1 percent had in-patient beds. Responding to demand, the vast majority offer allopathic medicine despite the fact that some are qualified in Indian systems of medicine. The majority (87%) are educated to matric level those that have more education and/or training tend to operate in or around urban areas. Estimates of the number of informal providers nation-wide vary widely from 500,000 (based on surveys in Andhra Pradesh and Utter Pradesh) to 1.27 million assuming that that each village has on average two such informal providers.[18]

RMPs each see between 20-50 patients per day for which they would received anywhere between Rs10-50 per consultation, depending on the ailment and the state. Higher consultation fees are charged in richer states. Despite their lack of knowledge and frequent involvement in potentially harmful practices they continue to hold the public's trust and earn a comfortable living from consultation fees and commissions for referrals to local private hospitals.

In the absence of regulation, such providers have been allowed to prosper, especially in the rural areas where they are often the only form of easily accessible care. Adapting flexibly to demand, some RMPs are peripatetic visiting two or more villages during the week. Villagers stated that the reasons for using RMPs include; the practice is open at convenient times (usually from 8am – 1pm and from 6pm –10pm). Practices where the RMP lives on the premises are open all the time. Moreover, RMPs are prepared to make house calls on elderly or incapacitated patients, and often have a good standing within the community. They uniformly treat patients with kindness and respect. Another attractive feature is service provided on credit to those who cannot afford to pay immediately.

Not For Profit (NFP) sector

Although the NGO sector and the not-for-profit sector more broadly, is widely discussed in India, it accounts for a tiny proportion of health care provision. In most states, the share of the NFP sector is less than 1 percent. NGOs, especially those funded internationally, tend to be more active in poorer states while locally-based religious organizations are able to attract more funding in richer states.

The NFP sector tend to mirror the facilities provided in the for-profit sector. However, NFP services are clustered in charitable clinics and larger hospitals. The small nursing home sector which characterizes the for profit sector is almost entirely absent from the NFP sector.

Some NFP facilities are established on a financially sustainable basis and are funded from user-charges, however, most require the support of philanthropic donations. As NFPs are not motivated by profit, these facilities often provide good quality care, need little regulation or oversight from government, are able to attract dedicated workers at lower than market rates and cater to the needs of the poor and those otherwise excluded from mainstream health care, often by charging lower rates. Moreover, they are also willing, budget permitting to take on health care challenges that the for-profit sector is not willing or able to take on, for instance running tuberculosis clinics, HIV/AIDs voluntary counseling and testing centers of adopting PHCs. Given these characteristics, governments have found it easy to create partnerships with the NFP sector for disease surveillance and control as well as to deliver and support the state or central government programs.

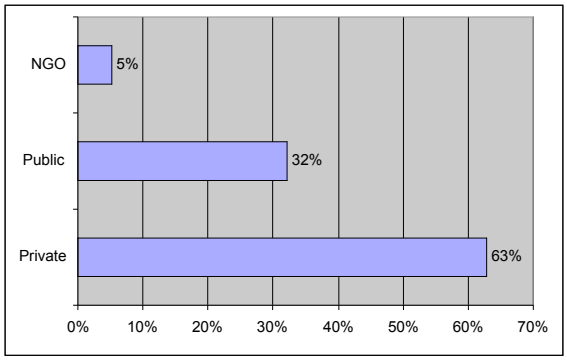
[17] More detailed information on RMPs is presented in Annex 3.
[18] The 2001 Census identified 638,365 villages in India.

The For Profit Sector

Accurate and comprehensive data on the size and structure of the private sector is unavailable on a nation-wide basis and many state-level statistics underestimate the true size of the private sector. However, it is possible to piece together a general overview of the for-profit sector through several good quality facility surveys that have been undertaken recently in several states.

The picture that emerges is one in which the private sector is much larger than the public sector. A recent facility survey in Andhra Pradesh indicated that the private for profit sector accounted for almost twice as many beds as the public sector (see Figure 3.2). This matches utilization data from the NFHS-II, NSSO and other sources.

Figure 3.2 : AP Health Facility Survey 2003
Beds (%) by type of facility



Source: Andhra Pradesh Health Institutions Database

The private for-profit sector is dominated by small, general facilities such as clinics and nursing homes that are individually owned. Facilities with less than 30 beds account for the vast majority of the private for-profit sector (83 percent in Karnataka). However, close to a third of private beds belong to large hospitals with more than 100 beds. Most for profit facilities are general hospitals (71%) while those focused on MCH account for (26%).[19]

Surveys have shown that the for-profit sector tends to charge more than the not-for-profit sector. Table 3.1 presents data from Bihar. Similar results were apparent in Punjab where, once the cost of external medicines was added, the for profit sector turned out to be cheaper than the government sector. Evidence from Karnataka illustrates that although there are "market rates" for many procedures in the private sector, charges vary greatly between private hospitals. The survey showed that facilities that were operated by charitable institutions generally charged the lowest fees, closely followed by those owned by individuals and partnerships. Corporate facilities run by limited companies charged twice as much for the same service.

Table 3.1 : Bihar, Health Care Charges (Rs)

Treatment	NGO	For profit	Informal	Government
OPD / VCT	5-10	30-50	5-25	Free
Vaccines	100	150	110 (cost +10%)	Free (if available)
Ward beds	400	500-550	N/A	50
Private bed	N/A	600	N/A	250-350

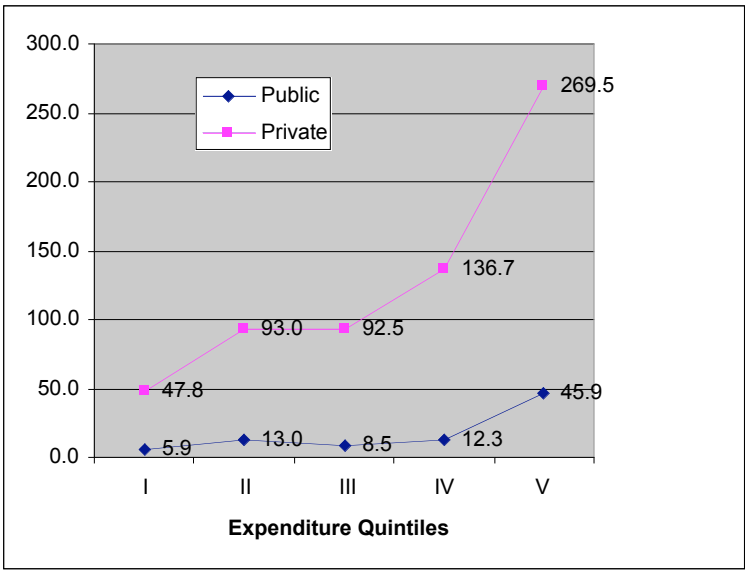
Source: Author's field visit

Private sector facilities tend to be clustered in a few urban centers. A review of the private sector in Punjab found two-third's of the state's 206 urban hospitals in just two of the 17 districts of Punjab. Only 7 percent of private beds are located in rural areas in Punjab.[20] This does not seem to deter poorer patients from seeking care but it adds to the total costs of treatment. Moreover, private hospitals tend to tailor their charges according to ability to pay much more than the public sector does. The highest rates

[19] Karnataka Facility Survey 1996.
[20] Survey of private practitioners in Punjab. Foundation for research and development of underprivileged groups 2001.

are found in larger cities and the lowest in rural and remote areas. Most private-for-profit hospitals are willing to offer concessionary or free services for the poor especially for consultations.

Figure 3.3 : Average hospital charges per inpatient (Rs/day)

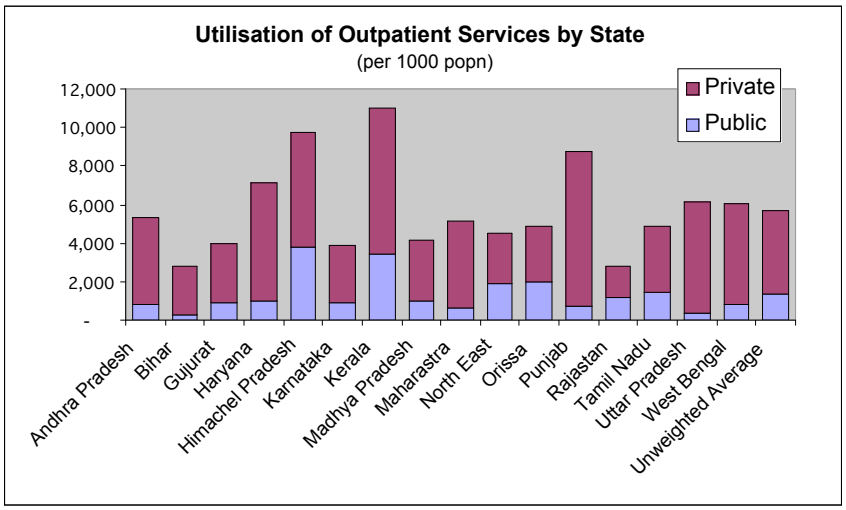


Source: NCAER. Who benefits from public spending in India 2000.

Utilization of the private sector

The private sector provides the majority of health care in India both in outpatient care (over 80 percent see Figure 3.4 and in-patient care, (close to 60 percent). In the poorest states such as Bihar and Uttar Pradesh, the public sector is completely dysfunctional and there are no effective alternatives to the private sector. At the other end of the spectrum, in the richest states such as Punjab and Maharashtra much of the population can afford and prefer private services even though government facilities do exist.

Figure 3.4



Source: Ajay Mahal based on National Sample Survey 1995-96, 52nd Round

The poor are increasingly using the services of private sector practitioners as the public sector is failing to reach and service such vulnerable groups in India (see Table 3.3). The majority of the population in rural areas utilize the services of unregulated and often unqualified medical practitioners, such as "Jhola Chap" doctors and faith healers. As almost 80 percent of the Indian population lives in rural areas, the informal private providers form an important sector to the health care options available for the poor in India. The government-run PHCs and CHCs are increasingly irrelevant despite receiving significant amounts of state budget to continue their operations.

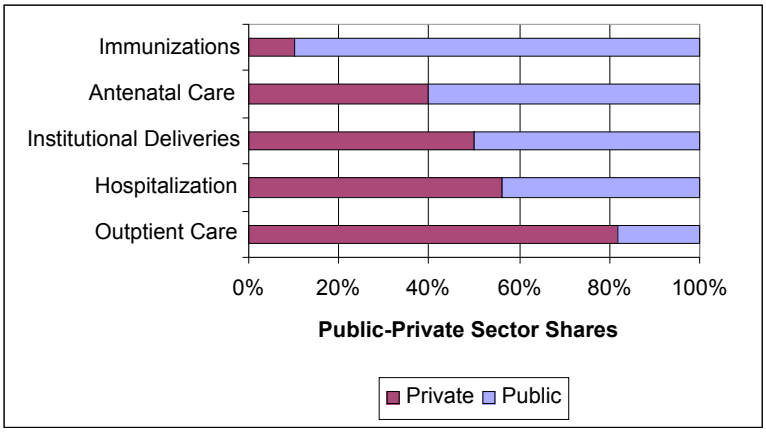
Table 3.3 - Health Care Service Provider Preference, by Quintile

Medical Practitioner/ Initial Consultation	Poorest Quintile	2nd Quintile	3rd Quintile	4th Quintile	Wealthiest Quintile	Total
Indigenous Practitioner / Faith Healer	8.6	11.7	7.8	8.4	5.3	8.3
RMPs (Quacks)	53.2	52.6	49.6	42.9	43.1	48.3
Chemist	0.9	1.6	1.7	3.0	0.9	1.6
Govt. Doctor – PHC, CHC..	5.1	4.0	5.2	6.4	5.5	5.2
Govt. Doctor – Hospital, Major Facility	9.0	10.4	10.6	12.9	14.7	11.5
Private Doctor – Clinic	23.0	19.4	24.7	24.7	30.5	24.5
Charitable, NGO, Other	0.2	0.3	0.5	1.8	0.1	0.5
Overall	100.0	100.0	100.0	100.0	100.0	100.0

(Source: UP/Bihar Poverty Study, 1998)

The private sector are getting increasingly involved in primary and even in preventative health care, especially maternal and child care, where they provide the majority of institutional deliveries in many states and a large percentage of ante-natal care. Rural women in Karnataka are twice as likely to visit a private than a public doctor when seeking ante-natal care. When they do visit a government doctor it is more likely to be in a higher level hospital than the local PHC.[21] Although the private sector are only provided 10 percent of immunizations in 1995-6 this figure is growing rapidly from a small base.[22]

Figure 3.5 : Public and Private Shares in Service Delivery 1995-6



Source: Ajay Mahal based on National Sample Survey 1995-96, 52nd Round

[21] Antenatal Care, Care-seeking and Morbidity in Rural Karnataka, India: Results of a Prospective Study, Mathews et. al., Asia Pacific Population Journal, June 2001.
[22] "How large is the role of the private sector in immunization in India?", Dr. Julia Walsh.

Challenges of increased private sector participation

Each part of the private sector is motivated by different objectives and therefore behaves in a unique way producing a variety of outcomes. Each part of the system has its own pros and cons as illustrated in the table below.

Table 3.4 : Pros and Cons of Private Sector Health Care

Sub-sector	Pros	Cons
Informal	Accessible Client-oriented Low cost	Poor quality care Difficult to mainstream Poorly educated
NGO	High quality Target the poor Low cost Involve the community	Small coverage Lack of resources Cannot be scaled-up Ad hoc interventions
For profit (small nursing homes)	Huge outreach / coverage	Moderate Cost Variable quality Clustered in cities
For profit (Corporate)	Highest quality Innovative Internationally regulated/accredited	Highest Cost Focused on tertiary care Located in urban centers

As explained above, informal providers are available in every village. Offering credit, convenient opening times and home visits they are extremely accessible to the population. Unfortunately they are not qualified to provide the type of services that almost all are offering including prescribing and administering powerful drugs and injectable medicines. Given their low levels of education, and poor record-keeping, it would be difficult to incorporate them into mainstream MCH, immunization and disease surveillance programs. However, several programs have successfully incorporated them to sell family planning products (see below).

The NGO and NFP sector is largely self-regulating and able to offer a high quality product and low cost to their users. They also target the poor, often playing a complementary role to public facilities by filling in the gaps in public and for-profit private provision. However, as most NGO activities are not centrally directed their interventions remain ad hoc and they are often at the mercy of donors who might lose interest or commitment. In the long term such models are not sustainable and cannot be scaled up. In the short term given the small size of the NGO sector they are not able to make a significant impact by playing a delivery role. However, given their objectives NGOs could play a useful supervisory in a system which involved more for-profit private sector delivery (see below).

The formal for-profit sector encompasses the most diverse group of practitioners and facilities. At the top end of services are hospitals offering international quality. However, such facilities are focused almost entirely on tertiary care and far too expensive to be relevant to the health care needs of the poor. Small private clinics and nursing homes are within the reach of some poor households but even their moderate costs can plunge such families into poverty. There are also several studies that indicate that parts of the for-profit private sector are involved in unnecessary procedures e.g. high rates of caesarian sections, unwarranted tests and surgeries. Much of the private for-profit sector is also heavily underutilized with low occupancy rates in all but the most successful hospitals. Since the private-for-profit sector form the largest part of the health sector any future strategy to improve public health should take them into account.

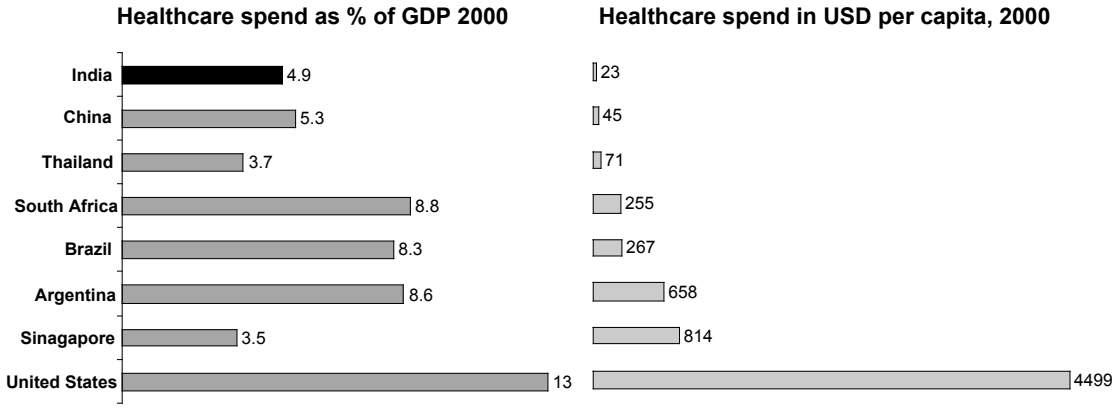
Overall the largest problem with the private sector is the fact that it has grown without any oversight or regulation from the public sector. This has resulted in a duplication of facilities in urban centers, variable quality services in the absence of licensing or accreditation, corrupt practices, variable charging and a lack of integration with public health issues such as disease surveillance. These areas should form the focus of a future strategy to improve the private sector's performance (see below).

IV Financing options for the poor

Total Health Care Spending

India's total health care spending as a percentage of GDP averaged 4.9 percent in 1997-2000, which was slightly higher than the low-income average, in the same period, of 4.3 percent. However, much more important than the total level of spending is the quality of that spending, its source and destination.

Figure 4.1 : Health Care Spending



Source: ICRA Indian Healthcare Industry 2003 and KPMG 2003.

Public spending

Public sector health spending in India accounts for only a small portion of total spending. India still lags behind other developing countries in public spending on health care, with only 0.6 percent of the country's GDP devoted to health care spending (and only 3 percent of total spending devoted to health care). This is just over half the average spent by other low income countries and less than one tenth that spent by the most developed countries (Table 4.1). As indicated above, much of this money disappears in corrupt practices such as absenteeism and simply increasing public expenditure without reforming the system is likely to be counterproductive.

Table 4.1 – India national health statistics compared to Low and High income countries.

Economy	Public expenditure on health % of GDP	Access to improved water source % of pop.	Access to sanitation % of pop.	Infant Mortality Rate Per 1,000 live births	Contraceptive prevalence rate % of Women	Total fertility rate Births per woman	Maternal mortality rate Per 100,000 live births
India	0.9	81	16	70	41	3.2	410
Low Income Countries	1.2	N/A	24	68	24	3.1	N/A
High Income Countries	10.2	N/A	N/A	6	75	1.7	N/A

(Source: World Development Report 2003- World Development Indicators)

It is important also to remember that public spending is heavily skewed as are other health indicators by state. Therefore health care spending in many of the richest states will be several times the average. A poor state like Bihar allocated just US$2 per capita, for health, in its 2003/4 budget.

An analysis of state spending patterns also illustrates that far too much public money is devoted to tertiary and secondary care and too little devoted to primary. Chronic illnesses that require treatment in tertiary care facilities have all the characteristics of a private good and it is questionable whether government should provide any public money to tertiary hospitals and medical colleges. Providing the poor with viable insurance options to cover catastrophic illness may be a more sensible solution (see below).

Public spending is also heavily skewed towards spending on salaries with an inadequate budget for drugs and often non-existent budget for maintenance. Punjab's state budget is symptomatic of this problem with 94 percent of the state budget devoted to salaries (see Table 4.2 below).

Table 4.2: Punjab State Health Expenditure By Inputs

Inputs	2001-02 Actual	% of Total	% Excluding Grant in Aid
Salary and wages	4,839,737	78.29	93.8
Medical reimbursement	8,796	0.14	0.2
Supplies and material and drugs	91,631	1.48	1.8
Machinery and equipment	17,497	0.28	0.3
Minor works	0	0.00	0.0
Grant in Aid	1,021,221	16.52	
Other	202,838	2.28	3.9
Total	6,181,720	100.00	100.00

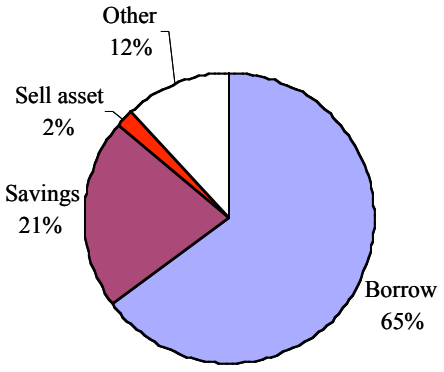
Source: Author's estimates on the basis of Punjab budget documents, various years.

Private Spending

The other main source of financing is household's out-of-pocket expenditure. The nascent health insurance sector in India accounts for a trivial portion of the overall market. Only the very rich, government employees and some formal sector workers enjoy health insurance. According to 1995/6 NSS estimates households total health spending was equal to Rs223 per capita and the vast majority of this was spent in private facilities. Given the statistics on health seeking behavior presented above, it is likely that much of this out-of-pocket expenditure was wasted on unnecessary drips and injections prescribed and administered by informal rural providers (see figure 4.3).

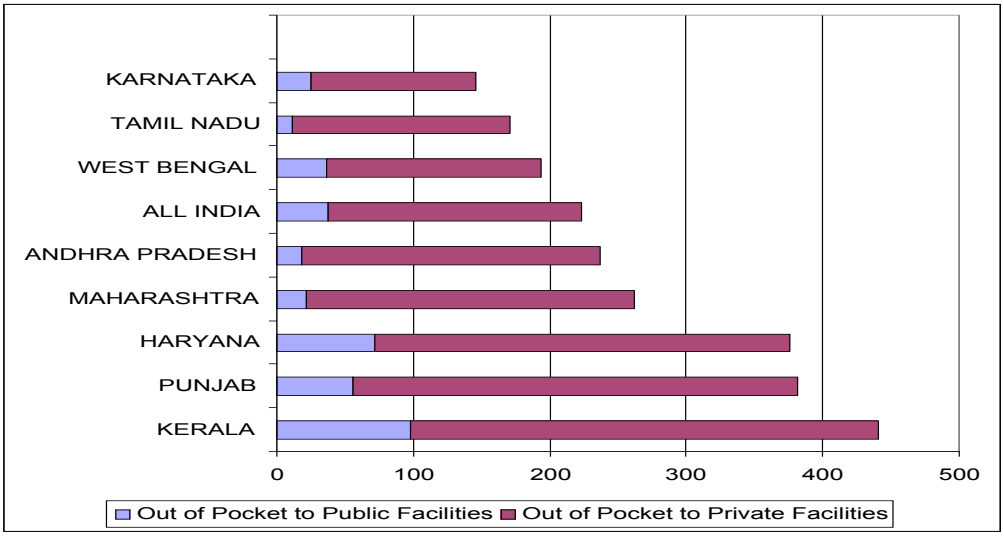
Given the fact that hospitalized Indians spend 60% of their total annual expenditure on medical care, (a large share from borrowed funds) there is a clear need for health care financing mechanisms that would pool the risk and alleviate some of the financial burden that is associated with hospitalization.

Figure 4.2: Economic burden of hospitalization for poorest 20%.



Source: Berman et. Al. Using NSS 52nd round.

Figure 4.3: Total Out-Of-Pocket Expenditure in Public and Private Facilities various Indian States, 1995-96-Rs/Person/Year



Source: IHSG, 2003, based on NSS 1995-96

Health Insurance

An effective health insurance scheme in India would provide coverage for day to day care and catastrophic coverage for the poor. The current market for private health insurance in India is not well developed. This results in large numbers of the poor falling below the poverty line when they are hit by illness. An effective insurance scheme with wide coverage and affordable premiums would go a long way to reducing out-of-pocket expenditures for the poor. However, to be sustainable such a scheme would have to be financially viable and run efficiently.

In recent years, growth of the health insurance market has been constrained by several unviable government schemes launched largely for political purposes in quick succession only to be wound up following elections. Poorly designed government schemes such as the Universal Health Insurance Scheme (UHIS) cast the wider health insurance market in a poor light. Poorly implemented schemes such as the ESI scheme discourage more affluent workers from purchasing health insurance. Insurance schemes run by NGOs/CBOs although generally better performing are small, have limited coverage and depend on heavy donor subsidies that again perpetuate the same problems. However, in some situations they have met with success. (See Annex 4 for a successful example from Rwanda).

Government schemes have suffered from a low participation level, primarily due to the low quality of services that are provided as well the cumbersome claims settlement process. Many of these schemes do not cover minor ailments such as flu and malaria which further reduces its benefit and appeal to policy holders. With so many poor examples of health insurance operating in India it is not surprising that there is little understanding of health insurance as a concept especially among poor rural women, the most important target group for any scheme that aims to improve primary health outcomes.

However, there is untapped potential demand for a well structured health insurance product. Out-of-pocket payments even among the poorest groups is high. Taken together such payments exceed US$10 billion annually a huge untapped market by any standards. The private sector has begun to make inroads

into this market but since most corporate entities are tackling the high end of the market, their customers are already well covered by medical care and their efforts are unlikely to make any impact on health outcomes.

In order to impact health outcomes, insurance schemes must be targeted at vulnerable groups. However, for long term sustainability they must be financially viable. What is needed is a hybrid between community funded insurance schemes and private sector professional schemes. This section presents;

- Overview of prominent private health insurance schemes
- Overview of public health insurance schemes
- Initial observations on insurance market development

Box 4.1 : Medical Savings Account (MSAs) an alternative to traditional health insurance?

MSAs are health plans that combine a high deductible health insurance policy with a savings account. The savings account is controlled by the insured and is intended to pay routine health care expenses. MSAs have been tried in many countries (for example, China, South Africa, and US) following their introduction in Singapore. Initial indications are that MSAs work best when introduced in the absence of an established universal health insurance system and when supplemented by supply controls.

Singapore: Singapore's innovative approach in health financing system has been lauded for its low cost, excellent health outcomes, and consumer choice of providers and quality of care. The program is compulsory requiring employees to contribute 6-8 percent of their pre-tax wages. It combines universal medical savings accounts (Medisave) with supplementary programs (Medisheild, for catastrophic illness, Medifund, for the poor) to protect the poor and address potential market failures. The presence of a financially strong formal sector and the compulsory nature of the scheme have contributed to its apparent success (although there has been a resultant increase in inequity).[1]

China: China introduced MSAs initially in two big cities (5 million population) and is currently expanding the reach of the scheme to include 42 other cities covering about 70 percent of China's urban population. The members of MSA are eligible to pay out-of-pocket health care and premium for catastrophic insurance. According to an estimation the introduction of MSAs has lowered the cost of health care by about 25 percent in the original pilot area (Gratzer 2002).

United States: In United States a MSA is a special tax-sheltered savings account for medical bills (known as Archer MSA) and works in conjunction with a special low cost, high deductible health insurance policy to provide comprehensive health coverage at the lowest possible net cost. The scheme is currently restricted to the self employed and employees of small businesses. There are some indications that MSAs have helped to reduce the cost of health care.

South Africa: Following the deregulation of the insurance sector in 1994 virtually every type of health insurance plans (HMOs, PPOs, MSAs) entered the South African market. Since its debut a decade ago, MSAs are the most popular type of private health insurance constituting about 50 percent market share for private health insurance in South Africa covering 4.6 million people. A comparison between conventional insurance plans and MSAs indicates that on average South African families' discretionary spending was 47 percent lower under MSAs (Matisonn 2002). It concluded that patients opted for MSAs managed to control costs including those of prescribed medication, avoiding the cost associated with managed care. South African scheme is more flexible allowing varying deductible as against the across-the-board deductibles covering all medical services in the US.

Source: Rodney Lester 2004.
[1] For more on the Singapore model see Robert Taylor and Simon Blair, "Health Care Financing: Singapore's Innovative Approch, World Bank 2003

Overview of prominent private health insurance schemes

A ICICI-Lombard

ICICI-Lombard is a prominent joint venture primarily engaged in banking and insurance which currently offers two health products, a critical illness plan and a newly launched hospitalization product. Like other private sector insurance schemes it is marketed primarily to the upper and middle income groups. During the last five years, the company has seen a 20-22 percent increase in the sale of health insurance policies, and a 45 percent increase in premiums. Management attribute this success to their rapid response to the market's demand for cashless medical transactions.

The critical insurance plan provides cover against 18 critical illnesses such as cancer, bypass surgery, heart attack, kidney failure. The insured is compensated to the extent of the sum insured if during the policy period he/she is diagnosed to have contracted any one or more Critical Illnesses, and he/she survives for at least 30 days from the date of diagnosis. The premium depends upon the person's age, health status, and sum insured and includes significant exclusions.

The hospitalization insurance plan: is a product launched in November 2003 designed according to the guidelines (e.g. the requirement for a continuous stay of 24 hours prior to become eligible for hospitalization benefits). The premium is based on age-band, sum insured, and the result of a detailed application form focusing on health history. For a 40-year old person insured for a sum of Rs. 100,000, the premium is Rs. 2,000 per annum. For an individual aged 55 or above, a physical check up is required. After 4 years of continuous insurance, ICICI-Lombard will cover all pre-existing diseases. The product is sold to individuals, families and corporations with a policy discount for families.

ICICI-Lombard entered into an agreement with MEDSAFE and Paramount, two leading TPAs. Between them, they were able to develop a network of 1,600 hospitals nationwide that accept the TPA-ICICI-Lombard health cards issued to members. By showing the card, a member need not make a deposit upon admission nor a payment upon discharge. Those members who access care outside of the network are reimbursed 100 percent.

Marketing the plan: ICICI-Lombard has no agency force; instead it is marketing the product through SPICE telecoms company. The objective of the alliance was to increase reach at lower costs. SPICE has been in the telecoms market for 8 years and has 0.8 million subscribers. Its customers are primarily middle class. ICICI-Lombard gave SPICE a special premium rate for its customers it also receives a 15% commission for every policy sold.

After three months, the SPICE network generated Rs. 400,000 in premiums. This initial success has spawned the development of other alliances. However, at the present, ICICI-Lombard reports a claim ratio of 140 percent. At the moment ICICI is able to bear this cost as the health insurance products are seen as loss-leaders and the company is using the opportunity to cross-sell more lucrative property and marine insurance. To offset the high claim ratio, the company is planning to increase its number of policyholders and premiums.

Overview of public health insurance schemes

It is estimated that less than 9% of the Indian workforce is covered by health insurance through the Central Government Health Scheme, Employee State Insurance Scheme and Mediclaim. The proportion that is covered mostly belongs to the organized urban sector. For instance, Mediclaim largely covers formal sector workers (95%) including government officials with a high level of service. The vast

majority of its members (75%) live in urban areas and outreach to the rural areas and informal sectors is insignificant. Thus there is great scope for pooling of risks and resources through a well-managed and well targeted insurance scheme. A number of government and NGO-led initiatives are experimenting with alternative methods of addressing this issue including; (i) UNDP / Karuna Trust, (ii) Farmers cooperative scheme (iii) Jan Arogya (GOI) scheme. Each of these schemes in addition to the Mediclaim scheme is discussed in more detail below.

A UNDP / Karuna Trust Pilot Scheme

The National Insurance Corporation (NIC) has teamed up with UNDP and the Karuna Trust to pilot a community-based insurance scheme in B.R. Hills, Karnataka. The scheme is aimed at encouraging vulnerable groups (members of schedule castes and scheduled tribes in the community) to take advantage of public health care facilities. By reducing the costs of health care at public hospitals, it is hoped that the scheme will encourage the increased use of such services. The pilot scheme was also intended to introduce members of the community to the idea of health insurance.

A baseline survey conducted during the design phase of the scheme gathered information on the demographic and health characteristics of the population. It revealed that individuals pay about Rs150 per day in direct and indirect costs during periods of illness (See Table 12). The survey also showed that the costs of treatment for patients aged 5 and under was about half this amount, largely due to the fact that there are no lost earnings and/or travel costs for children so young. Interestingly the costs of treatment at a private hospital were only a little higher at Rs163 while treatment at a "quack" or chemist shop were significantly higher at Rs295 per day. The higher costs at both private facilities and quacks was almost all due to the increased costs of consultations and drugs. The largest part of the costs was made up of lost wages and the cost of drugs. These findings informed the design of the scheme.

Table 4.3 : Costs of treatment at government hospital in rural Karnataka*

Items	Rs	Percent
Consultation	193	11.9%
Drugs	180	11.1%
Diagnostics	153	9.5%
Patient travel	132	8.2%
Escort travel	143	8.8%
Additional prescriptions	130	8.0%
Wage loss of escorts	290	17.9%
Wage loss of patient	182	11.3%
Speed money	114	7.1%
Other	118	7.3%
Total cost	1617	100.0%
Average cost per day	**147**	

* T. Narsipura Taluk
Source: Community Health Insurance – Organization of a pilot project, Center for Population Dynamics.

Coverage under the scheme costs Rs30 (US$0.7) per person per year and entitles beneficiaries to receive payments for in-patient treatment in selected public hospitals. Those requiring in-patient treatment are paid Rs50 per day to cover transport costs to the hospital as well as lost wages. The scheme also pays the hospital an additional Rs50 per day to cover the costs of scarce medicines. At each participating hospital, a member of the Karuna Trust verifies the members' eligibility and makes the cash payments. The maximum payment per year is fixed at Rs2,500 (US$55) for a 25 day stay in hospital. The scheme is administered by the National Insurance Company (NIC) a large public insurance company.

The scheme is subsidized by the UNDP. The subsidies go towards the premiums to be paid by the poor.

(i) SC/ST members pay nothing.
(ii) Below the poverty line (BPL) members pay between Rs10-R15.
(iii) Above the poverty line (APL) members pay the full Rs30.

Interesting features of the scheme

- *Insurance to use public facilities:* It recognizes the reality that public facilities are not free and makes payments to the hospital on behalf of the patient. Some of the Rs50 per day payment to the hospital will be used to cover formal payments but the majority will cover speed money (money traditionally paid informally to health care providers to facilitate access to timely care) and money to purchase drugs that should be provided free of charge. Moreover the insurance can only be used if the patient receives treatment at certain designated public hospitals in the nearby area and therefore does not encourage competition between the private and public sectors. There is evidence that some of those insured are still using private health care because of the superior service they receive.

- *Compensates the sick for indirect costs of illness:* Most of the poor cannot afford to take a single day away from their work. Even relatively small payments for transport to and from the health care facility (often Rs20-Rs50) can deter the poor from in-patient treatment.

- *Covers individuals and not families:* The scheme is based on individual coverage rather than coverage of the whole family. It is felt that allowing individuals to join would encourage people to come forward. However, users of the scheme may decide only to enroll wage-earning individuals or may decide to discriminate against female members of the household.

- *Only covers in-patient treatment:* By only covering in-patient treatment and fixing the maximum and daily benefits receivable the scheme effectively reduces the possibility of corruption. However, it does not encourage the poor to use primary health care outpatient services. Minor ailments that could be treated effectively with early detection could therefore go undetected. There may even be an incentive for those with minor ailments to wait for treatment until they become serious enough to warrant in-patient care.

- *Community involvement:* The scheme empowers the local community and reduces administrative costs through the creation of village health committees at both the District and Taluk levels. Both committees meet once a fortnight to review the number of beneficiaries registered, issue of insurance policies, settling of claims, accounting for payments to hospitals and oversight of the hospital revolving funds.

Results to date

All of the SC/ST members of the community were enrolled quickly in the scheme taking advantage of the membership without having to pay a premium. A similar number of BPL individuals also decided to pay the subsidized premium and join the scheme. However, only 2% of the total group are from the non-poor i.e. those above the poverty line who were required to pay the full Rs30. In total the scheme has covered about 25% of the population in its first year of operation. Bed occupancy under the scheme has gradually increased to approximately 8 patients per day.

In its first four months of operation the scheme took in Rs 25 lakhs in premiums but only paid out Rs 2.5 lakhs. This is unsurprising given the relatively high premiums at Rs30 and the ceiling on the maximum annual payout which is Rs2,500. The managers of the scheme believe that all the community can be covered on a sustainable basis for just Rs10 per year (US 0.25) an amount which is judged to be affordable by even the poorest members of the community. Alternatively the premium could remain at the current level and the benefits could be expanded to cover outpatient care. The managers of the scheme are experimented with a range of possible options for the future.

B Farmers' Cooperative Insurance Scheme / Yashaswini

Government is piloting a number of similar schemes. In Karnataka, government launched a scheme in November 2002 entitled "Yashaswini" under which it is aiming to cover 2.5m farmers that form 90% of the cooperative movement. Members of farming cooperatives are offered Rs 1 Lakh coverage for catastrophic illness. The premium payable is Rs75 per year, of which the farmer pays Rs60 per year (in monthly installments of Rs5) and government pays the remaining Rs15 per year.

The design of the scheme is informed by a survey that showed that farmers suffered from heart diseases, bleeding stomach ulcers, burst appendix, gall stones, enlarged prostrate, cataracts and fractures. Therefore coverage under the scheme includes treatment for all such diseases. Members of the scheme can seek treatment at any one of 67 private and public hospitals participating in the scheme.

The scheme's success relies on the hospitals offering to set low rates for certain major operations in exchange for increased volumes. Many hospitals are running at very low occupancy rates (10% or lower) due to the high costs of care at their facilities. It also relies on the fact that only covers surgeries and only a small fraction of farmers go in for operations.

C Jan Arogya Scheme / Universal Health Insurance Scheme

The Government of India (GOI) is piloting a nation-wide Jan Arogya insurance scheme. For a premium of Rs365 (or Rs 1 per day), the scheme covers wage-earning members of the family. There is also an option to cover a family of upto 7 members for Rs1.5 per day and a family of more than 7 for Rs 2 per day. The scheme covers medical expenses up to Rs.30,000 towards hospitalization, a cover for death due to accident for Rs.25,000, and compensation due to loss of earning at the rate of Rs.50 per day up to a maximum of 15 days. To make the scheme affordable to BPL families, the Government has decided to contribute Rs.100 per year towards their annual premium. This scheme is effectively targeted to cover care at small, low-cost private nursing homes and/or government facilities and is marketed by the four state-owned insurance companies.

Table 4.4 : Benefit Schedule

Benefit	Benefit Detail	Benefit Amount	Conditions
Hospitalization	Room, board, doctors' fees, diagnostics, chemotherapy, radiotherapy, dialysis, pacemaker, artificial limbs, others.	Rs. 15,000 per illness or up to Rs 30,000 per annum per policy.[23]	Subject to benefit limits. Hospitalization[24] should be for a period of at least 24 hours.
Accidental death	Earning head of the family	Rs. 25,000	Defined as the person named in the policy.
Disability due to hospitalization	Earning head of the family	Rs. 50/day of hospitalization due to accident or illness up to maximum of 15 days.	Waiting period of 3 days.

In the absence of accreditation of hospitals, the plan established a definition of Hospital as either any government or private facility with at least 10-15 beds depending on location. The definition was premised on the belief that facilities with 15 beds, for example, would have better facilities and staff.

[23] For a family policy, the total benefit can be incurred by 1 or more members of the family.
[24] The plan recognizes that in certain treatments, this time limit may not apply due to technological advancements. In these cases, a 24-hour stay may not be required.

Therefore users could seek care at any hospital or nursing home registered with the local authorities and under the supervision of a registered and qualified medical practitioner. Hospitals owned and/or managed by an NGO, a Trust, or private hospitals with a fixed schedule of charges. The hospital should have a minimum of fifteen beds for class A and B cities, and ten beds for class C cities with a population of less than 0.5 million, with a fully equipped operating theater, a 24-hour complement of fully qualified nursing staff under the supervision and management of a fully qualified doctor.

Table 4.5 : Details of the Hospital Benefits

Benefit Detail	Limit
Room and board	Up to Rs. 150/day
ICU	Up to Rs. 300/day
Surgeon, anesthetist, consultant, specialist fees, nursing expenses	Up to Rs. 4,500 per illness/injury
Anesthesia, blood, oxygen, OT charges, medicines, diagnostic materials, X-ray, dialysis, radiotherapy, chemotherapy, cost of pacemaker and artificial limbs.	Up to Rs. 4,500 per illness/injury.
Total reimbursable expenses for any one illness.	Up to Rs. 15,000/illness or injury

Marketing Strategy

Upon launch, the plan was made available for sale through regular insurance agents and brokers. However, the number of policies sold was extremely low due to the low commission and inaccessibility of potential clients and the ability of clients to pay the premium in full. Although it was agreed that poor individuals could afford Rs 1 per day it did not follow that they could afford Rs 365 in one installment. The poor take up indicated that there was a mismatch between the distribution strategy and the product.

The public insurance companies decided to market the group policies through NGOs that could act as agents to reach the target market. They have developed relationships with a number of NGOs working in poor urban and in rural communities. These NGOs were trained on the features and benefits of the product. They are expected to offer UHIS to the people they are working with. Oriental Insurance has linked the NGOs to a TPA, TTK, selected by the central government to solely administer the UHIS.

In fact the original plan called for treating the product as a group plan, selling only to groups of 100.[25] This was meant to prevent adverse selection; however, this restriction was lifted recently because of the difficulty of gathering 100 individuals and families buying all at the same time, and being able to pay the premium in full.

It is claimed that penetration in the rural areas remained weak. Some of the reasons cited include a) the poor and rural residents' very limited understanding of the benefits and mechanics of health insurance b) still very few NGOs were participating in the scheme because health insurance was new to them. Those who have participated needed continuing orientation to get them to fully understand the mechanics, benefits, and features of UHIS. NGOs' coverage in terms of numbers of potential policy holders was also limited. Moreover, the scheme itself does not appear financially viable and given the meager incentives for the public insurance companies to market the scheme it is not surprising that the scheme's take up remains limited.

[25] Per the central government's actuarial computation, a health insurance policy becomes viable when covering 100 people.

The TPA and UHIS

TTK, the TPA for UHIS, has negotiated with a number of hospitals to accept cashless transactions for UHIS policyholders upon presentation of the TTK photo-ID health card. At the same time, TTK required all approved application forms to include photos of policyholder and dependents. The main drawback to this was the inability of the poor to pay for getting their photos taken. Thus, even when poor individuals have purchased the policy, they may not necessarily be able to access the benefits for lack of the photo-ID card.

The insurance companies have made this problem known to the government. According to Oriental Insurance, in the very near future, the government might ask TTK to allow UHIS policyholders to use their BPL or voting photo cards in lieu of a dedicated health card when accessing services and benefits.

Issues and Concerns

There are a number of concerns with the scheme in its current form highlighted below;

- **Accessing care**: In many rural areas of AP, there is a dearth of hospitals that fulfill the requirements set forth in the UHIS guidelines. In many instances, the nearest facilities with beds are the PHCs, usually with 5-6 beds, but they provide very limited in-patient care. According to some experts many of the privately owned hospitals, whether allopathic or non-allopathic, have less than 10 beds. In the tribal areas, only RMPs and other quacks are present. In this scenario, many of the policy holders find it hard to get the hospitalization they require, rendering their policies practically inutile.[26]

- **Obtaining the government subsidy**: Those belonging to the BPL group may not necessarily be able to enjoy the benefit of the subsidy as the prerequisite is difficult to fulfill—getting a certificate from the local tax collector attesting that their income is within that of a BPL. In AP less than 2 percent of policies have been sold to BPL families. There could be other options such as using the BPL card.

- **Marketing reach and premium payment**: Using NGOs as the major agents of UHIS makes sense, but their numbers are low and their reach is limited. Even when the NGOs are able to convince an individual or a family to purchase the product, more often than not, the target clients do not have the money to pay the premium in full. Many of the NGOs could not afford to advance the premium payment, and even if they could, they did not have the wherewithal to make the daily collection of Rs. 1 or Rs. 1.50 or Rs. 2 a day from policy holders. This seems to be one of the main barriers to coverage.

- **Cover for OPD, including immunization**: Although the premium is considered by many to be reasonable and affordable even for poor families, who actually spend more per year for private health care, a substantial percentage of their total expenditure represents out-patient care.[27] This proviso seemed to have been predicated on a "vibrant" primary health care system—from the sub-centers to the PHC that efficiently provide preventive and curative out-patient services and primary health care for free.

- **Determining Pre-Existing Diseases:** The issue of pre-existing diseases hinges on who has the final determination of a policyholder's pre-existing diseases. With the poor's inability to access qualified

[26] Dr Shyam Ashtekar, Primary Health Care Group, Bharat Vaidyaka Sanstha, Sriramwadi, M.G. Road, Nasik 422 001.
[27] Financing of Primary Health Care in Andhra Pradesh, Sujatha Rao, et al. September 1997

providers most of the time and the low level of literacy among the targets, who will certify the pre-existing diseases? Who will have the onus of proving pre-existing conditions? This could be a major reason for rejecting claims. How will UHIS offer a relief to the poor suffering from pre-existing conditions and chronic illnesses?

- **Cover for maternity delivery**: The exclusion of maternity services, seen to be not an illness, works against the attainment of a priority objective of the central and state governments—that of decreasing MMR, and successfully implementing its strategy of increasing facility-based childbirth. With most rural hospitals, public and private, charging from Rs.600-2000, depending on area and facility, its inclusion in the UHIS would greatly contribute to attaining the MMR related goals of the government.

Table 4.6 : Breakdown of UHIS expenses

Premium	**Rs. 365**
Allocation for Claims:	80%
Commissions:	15%
TPA fees:	20%
Total:	115%

- **Financial sustainability of UHIS**: Based on information from Oriental Insurance, the following is the breakdown of expenses for an individual policy. Clearly, the government subsidizes all policy holders of UHIS, with the biggest subsidy going to the poor. The issue of sustainability is further aggravated by the very small numbers of policyholders, forestalling the advantages of risk pooling, and eroded further by adverse selection when it revised the product classification from group to individual.

D MediClaim

MediClaim is reputedly the best selling health insurance product of the government. Marketed through the government insurance companies, it covers about 2.5 million people in the country or about 0.5 percent of the population. This product provides institutional hospitalization benefits or domiciliary hospitalization benefits. It is available to individuals, families and groups.

Group Mediclaim is available to a minimum of 100 members, it pays for medical expenses incurred by a policyholder while in the hospital, either in an institution or at home, under the following conditions: a) In case of a sudden illness b) In case of an accident c) In case of surgery which is indicated as part the treatment of a disease which has arisen during the policy period. Except in cases of domiciliary hospitalization, pre and post hospitalization is covered up to 30 days and 60 days respectively. There are **no** annual limits or sub-limits set within an illness episode. The natural limit is the amount of sum insured and a limit for domiciliary hospitalization.

Coverage is for **all** employees of a company. All premiums are paid in full prior to coverage. Groups get the additional benefit of a group discount. Major exclusions include;

- Any pre-existing disease
- Any expense incurred during first 30 days of cover except injury due to accident
- Any expenses related to family planning
- Treatment for cataracts, benign prostatic hypertrophy, hysterectomy, menorrhagia or fibromyoma, hernia, fistula of anus, piles, sinusitis, asthma, bronchitis
- All Psychiatric or Psychosomatic disorders

Individual/Family Mediclaim is a replica of the group policy except that premiums are based on age up to 90 years old, and to a certain extent, health, determined through a detailed application form. Family

policies are subject to a family discount. Major exclusions include any expenses incurred in respect of any treatment relating to pregnancy and child birth.

Table 4.7 : Mediclaim key parameters, 2003.

Sum Insured	Limits for Domiciliary Hospitalization	<35	36-45	46-55	56-65	66-70	71-75	76-90
15,000[28]	3,000	213	232	331	379	427	455	551
30,000	6,000	366	398	572	648	723	779	971
90,000	18,000	1,182	1,285	1,840	2,088	2,336	2,508	3,114
500,000[29]	50,000							

The mediclaim scheme also offers a cumulative bonus of 5% increase in sum insured for every claim-free year of insurance up to a maximum of 10 years. As health insurance is a new product in India there is little awareness or understanding of the need to pay for the possibility of something happening. To overcome this. Mediclaim offers a further benefit, for every 4 years of claim-free and continuous coverage, the policyholder is entitled to reimbursement of cost of a medical check-up up to the equivalent of 1% of average of sum insured during the 4 years.

Remaining concerns

- Spurious claims are reportedly very high for both individual and group due to collusion between the policyholder and the provider.
- A major concern is adverse selection as majority of individual policyholders are aged 45 and above, yet, they are not subjected to any pre-coverage medical check-up. Many also conceal their pre-existing illnesses.
- Including family planning from the list of benefits for group policies could avert utilization of maternity benefits.
- The policy does not include any preventive nor disease prevention programs, yet, these could avert many instances of hospitalization.
- An annual physical check-up could also detect, and therefore avert, potential major illnesses that would require hospitalization.
- Out-patient care could have helped detect early on-set of illnesses.
- With the increasing incidence of "lifestyle" diseases, a more proactive preventive health program can reduce the potential number and cost of hospitalizations.
- Agents are less discerning in identifying and going after business. Thus, more time is spent by the insurance company in verifying and re-checking the potential policyholders.

E Employee's State Insurance[30]

The Employee State Insurance Scheme (ESIS) is a social security system that provides medical care and cash benefits during sickness, pregnancy, disablement, and death due to employment-related injuries to workers and employees of private companies, institutions, and other private business entities. It was aimed at factories employing 10 or more workers but also covers shops and establishments employing 20 or more workers. The scheme has grown rapidly since inception and now covers 230,000 factories and establishments across the country benefiting 8.6 million families or about 34 million individuals. It is a

[28] Minimum
[29] Maximum
[30] See Andhra Pradesh : Rapid Private Sector Assessment for more details on the ESI scheme.

compulsory scheme, and the private sector equivalent of the Central Government Health Scheme (CGHS), which is for central government employees. Together the two schemes reportedly cover about 3 percent of the population.

Who can be covered?

- Employees earning Rs. 6,500[31], excluding overtime employed in
  - Non-seasonal factories using power and employing 10 or more employees
  - Non-seasonal factories not using power and employing 20 or more employees
  - Establishments, such as shops, hotels, restaurants, etc. employing 20 or more employees

- Dependents of employees up to 4, including children up to 21 years of age and dependent parents (medical benefit only)

- Retired insured persons and spouses (medical benefit only)

- Insured persons who ceased to be insurable due to permanent disablement from work-related injury and spouses upon payment of a contribution of Rs. 120 per annum. (medical benefit only)

Medical Benefits

The scheme provides a number of in and out-patient benefits including; hospitalization, specialist services, drugs, diagnostics, etc. It also provides for immunization and maternity benefits as well as family planning and cash incentives to those undergoing sterilization. Cash benefits include; sickness benefit-50% of wages up to 91 days, with extended sickness benefit provision for long-term illnesses such as TB, Leprosy, mental and malignant diseases. An accident benefit provides a daily wage plus 20 percent. A death benefit-pension is also paid to dependents of those insured.

- Out-Patient—consultation and drugs are provided through ESI-owned dispensaries or through a panel of private medical practitioners paid under capitation of Rs. 120 per annum per insured person. Each private practitioner is allowed to register up to 1,000 insured persons. Special drugs are dispensed through a list of accredited private pharmacies. If not available and are purchased by the insured, ESI will reimburse.

- In-patient—hospitalization is provided in ESI-owned hospitals. For tertiary care, a referral from an ESI secondary facility is needed to go to an ESI, government or networked private tertiary hospital. There are presently no caps on hospitalization.
- Occupational diseases—patients diagnosed with occupational diseases are referred to ESI Occupational Diseases Centers or to ESI hospitals with bed allocation for occupational diseases.

Financing [32]

ESI is financed primarily through employee and employer's contributions. Employees contribute 1.75% of their monthly salary while employers contribute 4.75% of the monthly salary of an employee to finance the scheme. The government also has a mandated ceiling of expenditure on medical care. The scheme has a number of interesting features that allow it to be self-financing;

[31] This amount is set to go up to Rs. 7,500 by April 2004. Those earning less than Rs. 40 a day are still covered but are exempted from the employee portion of the contributions.
[32] Standard Note on Employees' State Insurance Scheme of India as of January 1, 2003.

- *Mandatory*: The scheme is compulsory and therefore avoids some of the problems associated with adverse selection that have plagued other schemes.

- *Combining health care insurance with service provision* removes the potential for collusion between the patient and the hospital to raise fraudulent bills.

- *Contributions*: The rate of contributions is determined by the threshold for those eligible for the scheme. Raising the threshold automatically increases the amount of money coming into the scheme – so effectively the level is set at the rate at which the scheme is financially viable.

- *Rationing*: There is anecdotal evidence that the facilities are widely underutilized and that they are of very poor quality which discourages many members from availing themselves of their services. According to a WHO report, "Poor quality and delivery of services; delay in enrolment and disbursement of cash benefits; non-coverage of temporary workers and their families" characterized the ESIS. [33]

Initial observations on insurance market development

Table 4.8: Summary of selected insurance schemes

Scheme	Premium	Benefit	Maximum	Coverage
Mediclaim	Depends on characteristics	Rs15,000-500,000	Rs500,000	Formal sector
UNDP/Karuna	Rs30	Rs100 per day (inpatient)	Rs2,500	All (poor subsidized)
Yashaswini	Rs75	Only in-patient	Upto Rs100,000	Farmers (subsidy of Rs 15)
Jan Arogya	Rs365 (individual) Rs547 (family <7) Rs730 (family >7)	Inpatient Accident Lost wages	Rs30,000 Rs25,000 Rs50 / day	All (poor subsidized Rs100)
ESI	Employee contribution 1.75% Employer contribution 4.75%	Lost wages Maternity Accident cover Hospitalization	Rs 600 per annum	Formal sector workers earning Rs6,500 per month or less.

A comparison of the various insurance schemes being piloted raises the following issues:

- *Coverage of outpatient care*: Most schemes do not address many of the issues raised by the review of the burden of disease as they do not cover outpatient care or basic dental and eye care. Most of the schemes implicitly or explicitly believe that outpatient care is much more affordable than inpatient care and is much harder to verify.

- *Maternal health*: Targeting individuals and or wage earners as many insurance schemes do, is likely to discriminate against women who spend a lot of their time in non-wage labor or childcare functions. The maternal mortality rate at 408 per 100,000 births is very high and normal delivery accounts for 23 percent of hospitalizations in India and obstetric care is the fifth leading reason

[33] Salient features of important health insurance schemes in India, 1998 Source: WHO/SEARO, Regional Health Forum: Volume 4, Number 1&2, 2000

for outpatient visits. Given this situation, future schemes could consider special schemes targeted at vulnerable women.

- *Subsidizing schemes:* Many of the schemes include a subsidy element. However, the subsidies are all designed with reference to the individual as the unit of analysis i.e. are based around the idea that government should be helping the poor. An alternative method of targeting subsidies would be to design subsidized schemes that covered only health care services with a public good element e.g. immunizations, communicable diseases, health education.

- *Catastrophic coverage:* To some extent all the schemes are aimed at providing catastrophic coverage to the individual. While it is true that many vulnerable individuals and their families fall into poverty as a result of serious illness it does not follow that public health care resources should be allocated to cover the costs of secondary or tertiary treatment of such illnesses. Such schemes should be designed within the framework of a comprehensive health care expenditure review and health care financing plan.

- *Involving the private sector*: In theory the most efficient health care delivery and health insurance systems would allow private sector health care providers to compete with the public sector on an equal footing. This would entail deriving accurate public sector unit costs for all major types of illness covered by the insurance scheme. If this information was available it could be used to cap payouts under the scheme, thereby reducing costs. It would also allow the private sector to bid effectively for patients. However, government officials currently have little idea of the unit costs of even the most basic treatments in the public sector. This is clearly an area that would benefit from increased government attention.

- *Using Gate-keepers*: Gate-keepers are primary health care providers that ensure that appropriate care is taken. They prevent individuals from obtaining expensive specialty care that is neither necessary or appropriate.

- *Unifying insurance and health care provision*: One of the major strengths of the ESI scheme is that it combines healthcare provision with mandatory insurance. As the hospital and the insurer are effectively one entity there is no incentive for the patient to collude with the hospital to submit fraudulent bills to the insurer.

- *Controlling provider quality*: The managed care model has shown how a selection of providers at pre-negotiated rates can bring down total cost and improve quality. This could be achieved through a voluntary accreditation system or more formal means. It could also be augmented with patient satisfaction surveys.

- *Improving financial viability*: Many of the government schemes are not financially viable and in fact have rarely aimed at financial viability. However, most private schemes currently being developed are yet to breakeven. Part of the issue is that the chronic lack of data hampers a more reliable actuarial approach to measuring risk. Improving data gathering would resolve this issue.

- *Insurance legislation*: Current insurance legislation prohibits small insurers from entering the market. Although the minimal capital requirements were originally established to protect consumers from smaller companies that might easily collapse, such requirements are no substitute for improved insurance regulation. The capital requirements should be reviewed within the broader context of strengthening insurance regulation in India.

Box 4.2 Building a Savings Fund for Self Help Groups

The Kurji Holy Family Hospital is a missionary-run facility operating in Patna since 1939. This 300-bed secondary general hospital provides general and specialty services. As part of its mission to help provide equal access to quality health care for all, it established two (2) community health centers (CHC). One is located within the hospital compound to give care to poor residents living in the surrounding slum communities within 10 km from Kurji; the other is located in Maner Block, a rural district. Immunization, ante-natal care, baby weighing, family planning counseling and commodities distribution, and health education classes are provided for a Rs 10 initial registration fee. Consultations for minor illnesses are also available for Rs 10 for initial registration and Rs 5 for subsequent visits. Vaccines and commodities are supplied by the government.

To complement its health services, each CHC organizes women-only self help groups (SHG). In the CHC in Patna, 8 SHGs have been organized in a slum area where about 150,000 people reside. Each SHG created an all purpose savings fund from fixed contributions of its members. Loans can be made from the fund for various purposes, such as micro-credit for small businesses and for health expenses.

The SHG in Batta B is called "Bajrang". It has 10 members, which is typical for an SHG. The membership agreed to contribute Rs 50.00 per month per member. From these contributions, it has loaned out a total of Rs. 10,500 to its members. It generates additional income from interest on loans, bank interest, and fines imposed on members for infractions. As of January 16, it has a total bank deposit of Rs. 9,835. The fund has been able to cover medical costs for various treatments preventing the members of the group from falling into debt.

V Engaging the private sector to care for the poor

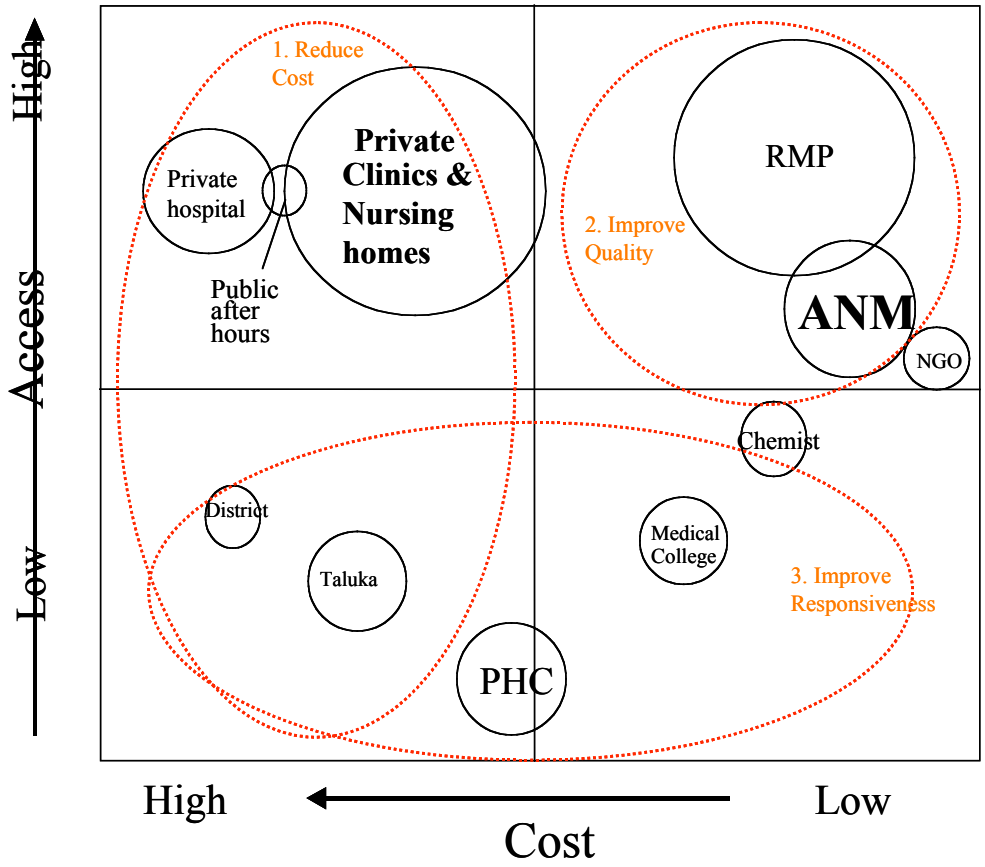
Summary of the challenge

There is a huge unmet demand for improved primary health care interventions. Central and state governments are focused on reducing the IMR (69/1000) and MMR (440/100,000) as well as reducing communicable diseases (increasing the percentage of children immunized from the current 53% to 90% by 2020). In addition to these health challenges, almost half the children in India suffer from some form of malnutrition and half the women suffer from anemia. Improving primary health care services as well as nutritional practices and emergency obstetric care are the keys to improving these health indicators.

Improving health outcomes will depend on improving the quality, outreach and responsiveness of primary health care providers. In the past, government's response has been to attempt to deliver these goods and services through public channels. Since the beginning of the 1990s, this effort has been a failure in all but a few states as earlier sections have shown. This section considers alternative responses, ways to improve primary health care for the poor by involving the private sector.

The diagram below illustrates how the various health care facilities and providers compare in terms of access and cost. It is a stylized framework for thinking about health care service provision for the poor.

Figure 5.1 : Cost and Access in Rural Health Service Provision



The size of the bubbles in the diagram is roughly indicative of the market share of each provider. (In practice the market shares would vary with the type of treatment and type of morbidity experienced).

The diagram summarizes the current status of health care options available to the poor in India. Ideally the poor should have easily accessible and low cost health care (i.e. the upper right-hand quadrant) that is also of high quality. This analysis implies three possible areas of intervention to improve the current situation, represented by the dashed ovals;

(i) **Reduce cost:** Options on the left-hand side of the diagram involve high costs. Firstly there are the high direct costs of private medical care and secondly there are the high costs associated with the time and transport to public facilities especially those at the higher levels. Given the high degree of out-of-pocket expenses, possible responses to this situation will involve innovative health insurance schemes and/or increasing government funding to the sector (see the previous section).

(ii) **Improve responsiveness:** Public facilities are unresponsive to the poor for a number of reasons. The reasons behind the failure of the PHC system is discussed in detail above. At the Taluka and District level the picture is almost entirely different. Public doctors at these facilities have a much higher status and sometimes a higher salary than those working in the rural areas. They are more willing to locate to such hospitals in urban centers as they have the amenities that they are looking for such as good schools for their children. Therefore absenteeism is less of a problem they are also better-stocked with drugs and finally given the collapse of the PHC system they are inundated with large amounts of patients that should have been seen at the primary level.

(iii) **Improve quality:** Facilities that are available locally and cheaply to the poor especially the services offered by informal rural providers fill a need for low-cost easily accessible services. However, as many RMPs lack even the most basic medical training, the quality of their care is extremely poor. In many cases the cure may be far worse than the disease.

Suggested policy recommendations in each of these areas are highlighted in the final section below are some case studies that describe successful Indian experiences in (i) contracting out, (ii) social franchising and (iii) improving public sector performance. International case studies are presented in a background paper to this study.

Successful Case Studies

Contracting out[34]

In July 2000, Andhra Pradesh established 192 Urban Health Centres (UHCs) each covering a population of 15-20,000. NGOs were contracted to run the centers on the basis of a model that included; (i) delivering services to the residents, (ii) community mobilization and (iii) behavior change communication to encourage greater take-up of services.

The UHC Advisory Committee and the District Health Officer (DHO) set the outputs expected from the UHC and conducted quarterly reviews of progress against established benchmarks. The UHC was allowed to charge Rs2 per visit and despite covering half the population covered by a government-run PHC, the UHC managers were provided with less than a quarter of the PHC budget. Free from

[34] See Andhra Pradesh : Rapid Private Sector Health Assessment for more details on this case study and see Contracting for primary health care for more information on contracting models in general.

government norms and standards, the UHC management were able to recruit staff such as ANMs on contract at half the government rate.

In their first few years of operation, the contracted UHCs have shown an impressive performance. Most notably increasing the proportion of pregnant women visited by a health worker from 10 percent to 95 percent and increasing the number of children fully immunized from 31 percent to 85 percent (see Table 5.1)

It is clear that measuring performance provided the NGOs with a powerful incentive to focus on results and outputs rather than inputs. Involving the community and engaging in behavior change also allowed the NGOs to respond effectively to local demand. The ability to sanction poor performers was also crucial to the success of the program. After the first three years of operation, 4 NGOs that did not manage to meet expected minimum standards did not have their contracts renewed. This also sent a powerful signal to those that continued with the program.

The program illustrated that even NGOs with no previous experience in health could easily and successfully take on the management and delivery of health care services through a UHC.

Table 5.1 : Performance of Contracted UHCs

Indicator (percent)	2000[1]	2002[2]
Pregnant women visited by health worker	10	95
ANCs registered before 16 weeks	46	65
Institutional deliveries	66	74
Post-natal women who received advice on breast feeding	26	80
New born babies weighed immediately after birth	42	75
Low birth weight babies	8	7
Children fully immunized	31	85

[1] Baseline Survey conducted by A.S.C.I January 2000.
[2] Evaluation conducted by TNS Mode in June 2003.

Social Franchising[35]

The idea behind social franchising programs is that if you can provide consumer goods such as coca cola to every poor village in the world, then it should be possible to provide pro-poor health care in a similar way by standardizing the product and the way it is delivered under a strong brand name. The program is based on the premise that there is significant demand from the poor and vulnerable groups that use private health care facilities and RMPs. However, there is little response from formal private providers and informal providers can only offer poor quality care.

Janani has been operating a franchising model in Bihar since 1996. It aims to provide family planning products to vulnerable communities. Janani sells pills, condoms and other family planning products such as rapid test services for pregnancy, blood pressure and diabetes etc. in urban areas through shops and pharmacies and in rural areas through a network of RMPs. The centers are branded with the Titli butterfly logo and assure the end-users of the quality and service that they expect at a transparent and predictable price. The franchiser provides the retail owners (always at least one female RMP) with

[35] For more on the franchising model and the Janani case study see background paper, Franchising for Primary Health Care.

training and products that are purchased in bulk and therefore provided at less than the market price. The Titli centers are supported by a network of clinics to which patients are referred. Each clinic has a qualified doctor, an ANM, administrator, counselor and lab technician. They operate under the Surya (sun) brand name.

The Titli center owners pay an annual membership fee equivalent of $12 for these services. Membership fees cover the cost of advertising and marketing campaigns and franchise maintenance. The marketing campaigns are based on empowering the poor through education not just information on the franchise products but information more generally on family planning issues.

The focus on quality of care is ensured through a network of franchise supervisors that ensure transparent pricing, infection control, waste disposal and diagnostic facilities at the Titli centers and the clinics. In general the franchising model works as it is self-regulating. Membership in the franchise has the potential to improve outcomes for both the provider and the client. For the providers, there is the potential for increased revenue through increased volume and lower input costs as well as expanded range of services and access to training and advertising services. Meanwhile the client is assured of high quality care, a consistent stock of important products, clean facilities and courteous service. Although the current pilots in Indian states are based around family planning services, the model could in theory be used to deliver other health services. Although it is more difficult to provide services than products.

Although the model has been very successful in expanding outreach of family planning services to rural areas, it has not stopped the RMPs from continuing to practice "quackery" with all its concomitant dangers. Other challenges faced by the model include the financial sustainability of the franchisors and to a lesser extent the franchisees. Those that include a public health component often require ongoing subsidies to remain viable. However, given the positive externalities associated with such primary health care interventions as family planning and immunizations it might be sensible for government to partially subsidize the costs of the public good components of these services.

Improving public sector performance[36]

In 1996, Punjab embarked on an ambitious program to improve the state's public secondary health system. The initiative began with the introduction of the Punjab Health Systems Corporation (PHSC) established to run the secondary health facilities outside the remit of the stifling government bureaucracy.

User charges were introduced at all the facilities and the revenue generated was retained at the facility level to provide drugs, patient facilities, equipment and building maintenance. Although user charges only account for 7 percent of spending they have made a great difference not only in providing for items that were not previously budgeted for e.g. maintenance but also in providing hospital management in greater autonomy in using the budget. The chief medical officer in each facility has the ability to waive user-charges for the poor and all BPL yellow card holders are provided with free treatment.

A Health Management Information System (HMIS) was established to provide timely and accurate information required to improve facility management. The computerization of hospital records and their publication on the internet[37] also established a transparent performance culture with each facility being graded on key indicators. The Corporation also introduced non-monetary incentives such as letters of appreciation to outstanding health workers that had far surpassed targets.

[36] For a more detailed explanation of this pros and cons of this case study see the background paper Punjab: Health Sector Assessment.
[37] See www.punjabhealth.org

The Corporation outsourced several non-clinical services such as ambulances and sanitation. Charging for ambulance use at Rs3.5/km provided the operators with a regular revenue from which to ensure that the fleet was always operational. Outsourcing sanitation resulted in very clean hospitals confirmed by a recent patient satisfaction survey which indicated that 71 percent of PHSC patients were satisfied with the cleanliness of the toilets compared to 42 percent in non-PHSC facilities.

The results of the reform program have been impressive with tremendous increases in key performance indicators. In the last two years alone, surgeries have increased by 58 percent, the number of deliveries by 36 percent and the number of laboratory tests by 82 percent.

Political Economy of Change

Whatever suggestions are adopted, reform of the health system will have to overcome powerful vested interests. The current system has evolved largely in response to the incentives embedded within the system. Changing the incentives will create winners and losers and therefore reformers can expect (i) that reforms will be strongly opposed by certain stakeholders and (ii) that reforms will only be adopted if reformers consider the political economy of change before designing the reform program. Some suggestions largely based on our discussions with key stakeholders are offered below.[38]

Who gains from the current situation?

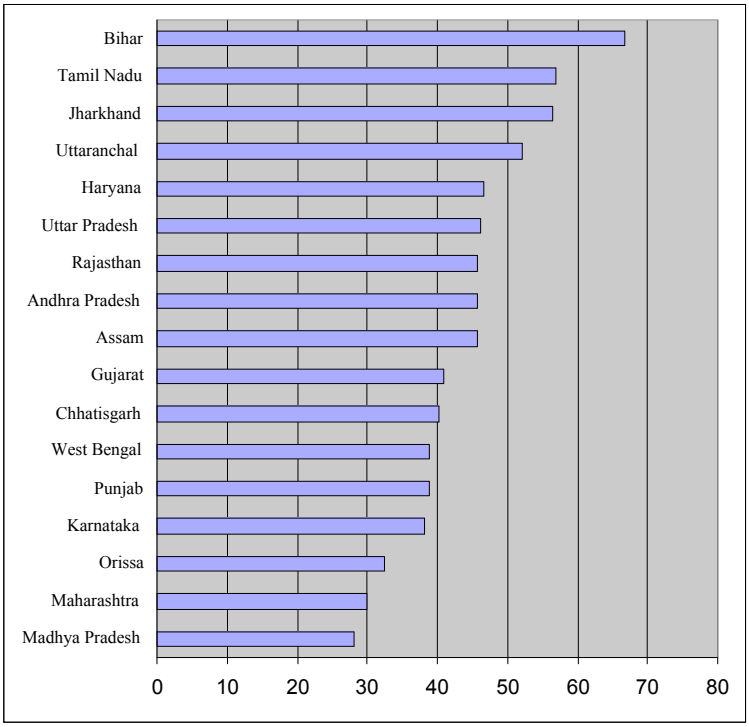
At the moment both the public and private sectors are failing to improve health outcomes in India. As explained above, the public sector is characterized by low levels of funding, poor incentives to perform and little or no effective oversight. Inadequate budgets result in unfilled posts and constant shortages of essential drugs. With no institutionalized incentives to perform, it is entirely upto the individual (especially the Medical Officers in charge of PHCs) whether or not they will offer decent health care services to the community and in fact, whether or not they will turn up for work. Table 5.2 indicates that between $1/3^{rd}$ – $2/3^{rd}$ of doctors are absent at PHCs throughout India. The corresponding numbers for other health workers are just as high (see Table A2.2)

Too often, doctors posted to rural areas will not be resident locally. Some will visit intermittently while others will not visit their official postings at all. It is reported that such doctors will collect their government salaries while being engaged in full-time private practice in nearby urban centers. By the time that complaints are lodged and investigated, the doctors will have been rotated to another district. This year for the first time, the Government of Karnataka dismissed two doctors from the service – their offence, not reporting for work during the last ten years. It is claimed that such doctors often escape censure by bribing their superiors and that corruption within the system is endemic.

Public doctors that do turn up, often charge patients for basic medical care that should be offered free of charge. Many also operate private practices after hours. Both practices blur the distinction between public and private practice.[39] Stakeholders consulted in the course of this study report that in such cases, their superior officers will receive a portion of the profits in return for turning a blind eye to these practices. It is also reported that the position of District Health Officer is one that carries a lot of prestige and status within the Department of Health and that this position offers an opportunity for individuals to extract payments from absentee doctors and others infringing the regulations.

[38] A full list of stakeholders consulted in each state is found in the state-level documents that accompany this main report.
[39] For instance see Peter Heywood, "Seeking and Financing Health Care in Andhra Pradesh".

Figure 5.2 PHC doctor absentee rates by state (%)



Notes: The absentee rate is the percentage of providers who are supposed to be present but are not on the day of an unannounced visit. *Source*: Provider Absence Project Research Team, World Bank 2004

Therefore any reform of the system that attempts to make doctors turn up in return for receiving their salaries is likely to encounter tremendous opposition from the doctors' associations. Early discussions with doctors and their associations undertaken during the course of this study illustrate that they are unwilling to consider alternative methods of oversight. For instance, one simple method of ensuring that doctors turn up is to allow the Panchayati Raj Institutions to play a more prominent and official role in the oversight of the doctors. Doctors have stated that they would not be willing to consider be sanctioned by the heads of local PRIs that are likely to have little knowledge of health care issues and be much less educated than the medical officers.

Another set of winners from the current situation are the quacks and informal providers. It is more than 15 years since the first Supreme Court edicts banned the practice of quackery and yet it continues to flourish all over the country. Governments are unwilling to implement this decision for the simple reason that RMPs constitute an important vote bank and are often closely connected to the Panchayati Raj in many villages. They outnumber qualified doctors by at least 10:1 and therefore wield considerable political clout by virtue of their numbers and their standing as opinion leaders in rural settings. Qualified doctors complain that often villagers have more faith in the healing capabilities of such quacks than they do in medical doctors.

In some areas, quacks are so powerful and well entrenched in the local community that they are able to drive out qualified public sector doctors that threaten them. In other communities, RMPs build lucrative symbiotic referral relationships with unscrupulous private sector doctors. They are often careful to share a percentage of their profits with the local police and elected officials to ensure that these groups offer their protection when needed.

In many ways, reforming the informal providers will prove much more difficult as government has little leverage over them other than the court rulings. They receive no funding from government and it is almost impossible and perhaps counterproductive to attempt to harass them out of business. Interestingly, it is government officials that are often most keen to drive them out of business pointing to the illegality of their current practices and their potential role as competitors to the public sector. Doctors we consulted have a more ambivalent attitude. They are aware that quacks can sometimes represent stiff competition for them in rural settings and that allowing others to practice medicine without a degree cheapens their profession. However, they are also aware that quacks can represent a lucrative source of income and referrals and hence the IMA's suggestion that quacks be registered and brought under the remit of PHCs and qualified doctors operating in the rural areas.

Who are the losers in the current system?

Several forms of fraud (e.g. absenteeism, drug procurement etc.) within the public sector clearly have a tremendously detrimental impact on health outcomes for the poor. Salaries quite often form 90 percent or more of the budget of Indian health facilities. If 30-65 percent of such salaries are going to absent health workers, this implies that upto half the public health budget is wasted. Moreover, the recent experience in contracting out the UHCs in Andhra Pradesh has shown that some government health workers are paid upto four times what they could earn outside the government. This clearly establishes lucrative government jobs as a source of patronage to be handed out by politicians to their supporters usually just before elections. The losers in such a system are the end-users especially those in rural areas.

Parts of the private sector are losing opportunities within the current situation. As long as government maintains a monopoly on the management and delivery of public health the private sector will be missing an opportunity to get involved. Medical colleges especially are interested in running PHCs to allow their trainee doctors to get first hand exposure to a variety of patients. There is clearly scope for government to capitalize on potential synergies in this area.

There is also a strong tradition of charitable work by both for-profit and NGOs that can be tapped successfully to augment limited public budgets devoted to health care. In all these cases ordinary people are the ultimate losers within this situation.

Who are the reform champions?

Key reformers within the state include senior government health officials who see the need for reform and are willing to experiment with pilot projects that can be replicated. However, they often come up against a bureaucracy that feels threatened by private sector participation. In many cases, the public sector does not have a clear understanding of what the term "private sector" and perhaps a better term might be "non-government sector". Many government officials believe that the private sector are corrupt, rent-seekers and that the private sector are only involved in high cost, tertiary care in urban centers. On the other hand the private sector are wary of getting involved with government especially in any ventures that might involve getting paid by government. They feel that government officials are self-centered individuals seeking opportunities for illicit payments and favors. Any successful reform program would have to start with a process of dialogue that would overcome such misunderstandings and mutual suspicions.

Other key stakeholders that have an incentive to implement reforms include motivated doctors and the general public especially the end-users of rural PHCs. Independent NGOs and their leaders have also proved strong proponents of reforms, able to hold the government accountable and raise the alarm to the most egregious examples of corruption and public sector failure.

The private sector is also a strong lobby group for increased private sector participation. However, most public sector health officials in India view the private sector with suspicion. Many are reluctant to encourage partnerships with the private sector whom they see as potential competitors. For instance in Andhra Pradesh a successful experiment with NGO contracting of Urban Health Centers (UHCs) has not been augmented to cover PHCs and government officials remain reluctant even to continue the current model.

Those that have the greatest interest in improved health care provision are the poor. Unfortunately they are also those with least voice in the process. Improved health care outcomes will require increased community mobilization, education and awareness. Government must also consider methods of empowering the people by adopting non-traditional techniques and community-based approaches usually piloted by NGOs. This is why a flexible contracting model that allows NGOs and for-profit private providers to run PHCs is potentially so powerful. It will introduce a results orientation and innovative methods of structuring and managing healthcare provision that a public sector monopoly will never be able to achieve.

Institutions required for change

As the section above indicates there are powerful vested interests against private sector participation in health. However, an additional constraining factor is the lack of capacity (managerial and technical), the technical complexities and the fiscal risks and space required to pilot such initiatives. Experience in other countries most notably Chile and Colombia have shown that governments need to build institutional capacity to deal with the transition from managing and financing public providers to maximizing the impact on the population.

At the core of this transition there are two changes that need to occur. Firstly, government needs to create a separate financing/ purchasing function either internal or external to the Ministry of Health. This would counterbalance the traditional provider role. Secondly, the newly created unit needs to shift financing from historical budgets to performance and results based financing. This groundwork is essential to be able to successful undertake contracting, demand-based financing or insurance and forms the heart of the first policy recommendation presented in the following section.

VI Policy Recommendations

Different solutions for each state

The above analysis illustrates that within India there are huge disparities between the states. Therefore a single policy prescription or "one size fits all" recommendation does not make sense in such a context. The background papers for each state highlight the most important health challenges and most promising policy options on a state-by-state basis. This section offers a range of policy suggestions that each state could consider depending on the particular health challenges, fiscal space, implementation capacity within each state. Building on the analysis in the previous section, the suggestions are grouped into the following areas;

- Improving stewardship and oversight
- Improving responsiveness
- Improving quality
- Reducing cost

Improving stewardship and oversight

This paper has illustrated that private sector health care delivery has grown without any guidance or oversight from the public sector. In turn this has led to duplication of facilities in urban centers, variable quality of services, corrupt practices and lack of integration of public health issues such as public health surveillance. It is vital that government improves its stewardship capacity and augments its remit to cover the private sector.

The organizational structure of government both at the central and state levels currently lacks a strong unit that can analyze health system performance and key health system strategies. An organizational locus for monitoring and evaluation of health system development, and consequent use of that information in policy design is also lacking. Along with this lack of organizational structure as a base for the government's stewardship role, there is also limited training and technical capacity amongst senior and mid-level officers to design, plan, implement, and evaluate major health system innovations such as health financing reform, or engagement of private providers in the provision of essential services. Strategic planning and stewardship over the whole sector are non-existent.

Policy Recommendation 1 – Government should strengthen its PPP capacity

The government should review its structure, and consider what organizational and capacity building strategies could be proposed to address the above deficiency. Possible actions to be considered include: developing a public private partnership unit at the state level and national levels, establishing a health policy institute outside of the government organizations and contracting out specific work on the private sector to existing institutes.

These units should develop a long term policy for national and state level private sector participation in health in particular they should;

- *Draft a vision statement or policy paper for the whole health sector:* Departments of Health at the center and in the states need to draft a policy paper for the whole sector i.e. both public and private, focusing on the primary level. The resulting paper would need to have wide-scale stakeholder consultation and debate before being adopted and approved by respective governments.

- *Partnerships with the private sector:* As the private sector is the first port of call for most illnesses an effective public health system must incorporate the private sector. At the very least government should consider methods for exchanging records on the most important communicable diseases. Government should consider bringing in private sector representatives to take part in the design and implementation of national health programs and priorities. Government can also build capacity to purchase primary health care from the private sector where appropriate (see above).

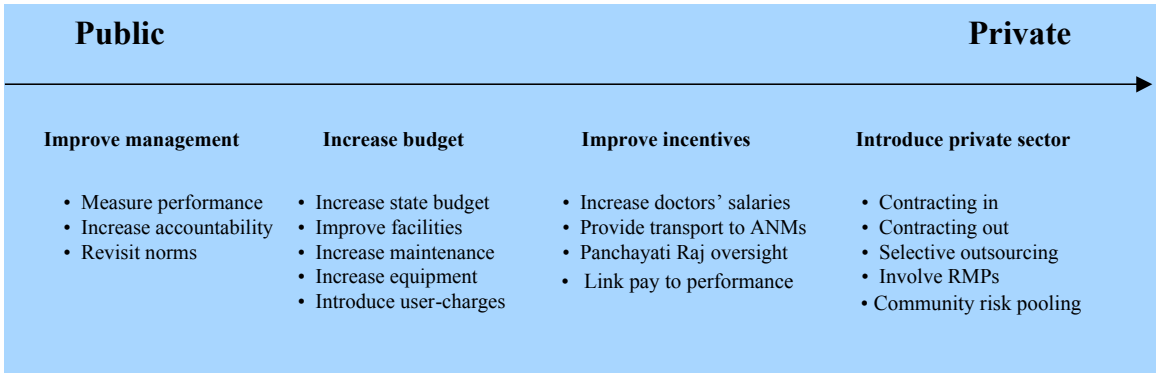
- *Review pertinent legislation:* In some cases, the current legal framework is not conducive to private sector participation in health. For instance, high minimum capital requirements for private insurance companies effectively protects the sector from competition. In some states outdated regulations constrict the ability of the formal private sector or drive them into informality. Any attempt to partner with the private sector should be based on a sound legal and up-to-date legal framework.

- *Increase capacity for strategic planning*: Government must augment its planning and reform capacity. This process should start with a realization that good doctors do not necessarily make for good managers. The skills required to be an eye surgeon are entirely different from those required to manage public health care or contract with the private sector. As such, top level positions in the department need to be filled with excellent managers, private sector representatives, public health specialists and health economists in addition to doctors.

Improving responsiveness

The above sections have shown that the current health system is not meeting the needs of the poor especially for low-cost, high-impact primary health care. The private sector is either focused on expensive tertiary care for the rich or providing poor quality informal provision for the poor. Meanwhile the public sector has failed to deliver even basic primary health care such as immunization, ante-natal care, and improved nutrition. Confronted with such a situation government can either improve the performance of the public sector or contract the private sector to provide primary health care. There are a range of options for reform that lie between these two poles. These options are presented in Figure 6.1 and are not intended to mutually exclusive.

Figure 6.1 : Methods to improve the PHCs



It is important to realize that inviting the private sector to deliver primary health care services does not mean that the public sector is withdrawing from this area. Rather it is changing its role from one of provider to one of financing, monitoring and policy formulation.

Policy Recommendation 2– Contract out the PHCs

Introducing private sector participation is perhaps the most promising and challenging reform option. States like Karnataka and Andhra Pradesh have shown that contracting out PHCs to NGOs can result in improved outcomes and reduced expenditure. States that already have a track record in contracting out to NGOs should consider building on this experience and scaling-up their efforts to include the for-profit sector. Other options available are contracting in and/or outsourcing selective functions to the private sector, for instance immunizations or ante-natal care.[40]

States that are new to private sector partnerships can start by piloting initiatives in geographical areas. Contracting the private sector to run a certain number of PHCs in a contiguous area has the advantage that it offers economies of scale and reduces the private sector costs of bidding. Focusing on a particular location also allows government to select a poorly performing area and reduces the spill-over effects of patients and diseases from other jurisdictions. The steps required to contract out PHCs to the private sector are spelt out in detail in the background paper to this study, "Contracting for primary health care".

Another way to improve the responsiveness of the system is through demand-led financing using vouchers or health cards. Voucher programs are a potential way of increasing access for vulnerable groups. They have not been tried yet in India but have been successful in other countries most notably in Nicaragua to provide reproductive health services to vulnerable groups and in the Philippines. They work best for discrete services where there is little or no opportunity for patients or doctors to generate excess demand. The best demand side mechanisms would allow BPL households access to either public or private facilities. More detailed information on voucher schemes is included in the background paper on international case studies.

Improving Public Sector Management

In theory the public sector could manage PHCs as well as the private sector. In practice this does not happen as the incentive framework within the public sector is not conducive to the efficient delivery of goods and services. Improving the incentive framework could involve introducing some of the management techniques used in the private sector such as measuring performance (and linking it to pay), holding absentee doctors and other health workers accountable, reducing the number of transfers etc. There is considerable scope for improvement within the current system. However, such improvements are likely to be marginal at best. An approach that relies on inflexible norms and standards, that is focused on inputs, is operated almost without management oversight, and is grossly underfunded will never be able to rise to the current health care challenges. Reform within the system would more beneficially start with a complete overhaul of the PHC structure and reconsideration of the existing PHC norms. Some suggestions along these lines are included in Annex 5 which also highlights the tremendous improvements that Punjab has seen through a corporatization of its secondary health facilities.

Improving Quality

The private sector is dominated by informal providers. They provide the majority of outpatient care and account for a large amount of out-of-pocket health care expenses especially for the poor. In the medium

[40] These options are discussed in detail in the background papers to this study.

term, informal providers will gradually disappear as the health system improves, rural villagers have access to better care and become better informed. In the short term informal providers are a reality of India's health system. Ignoring the informal providers will not make the problem disappear. Experience in Bihar illustrates that informal providers can play a role both through social franchising of family planning products and improved care of sick children.[41]

Policy Recommendation 3 - Devise a strategy for improving the performance of informal providers

Without pre-empting government's strategy some suggestions for improving the performance of informal providers are given below:

- *Mainstream some RMPs*: Some stakeholders have suggested that some informal providers could be mainstreamed and trained as general health workers. The average PHC covers around 30-35 villages and would therefore be likely to include an area in which upto 80 informal providers are operating. They could be brought under the control and supervision of a qualified doctor at the PHC. Although this idea seems appealing at first, it might prove unworkable in practice. Firstly, qualified doctors at the PHC are not effectively supervising the PHC staff much less a large number of unqualified practitioners in remote rural areas. An improvement in PHC operations would have to take place before this option could became a reality. Secondly as many RMPs are well paid making between Rs5-10,000 per month in consultations and reportedly several times that amount in referral commissions, they would be unwilling to be mainstreamed if it resulted in a reduction in their incomes.

- *Training and Accreditation:* A brief review of the operations of the RMPs illustrates that the vast majority are unqualified to practice allopathy. In giving injections and/or prescribing medicines to almost all their patients they are potentially exposing themselves and their patients to HIV/AIDS and other diseases. Research has shown that those that are provided with an intensive package of support including INFECTOM and observed case studies dramatically improve the quality of the care they provide to sick children.[42] Government could consider offering advice, information and possibly accreditation to the RMPs. This will ensure that they have the required information to offer safe injections and hopefully will move some way to replacing irrational treatments with evidence based medicine. Some RMPs currently pay for and attend training. If trained RMPs could charge higher prices or attract more clients there would be a greater incentive for them to attend training. However, this would require (i) training to be accompanied with some recognized form of certification or accreditation (which would help users to selected better quality care), (ii) government oversight of the training course material and provision and (iii) public demand for accredited providers, which could be stimulated through education and awareness campaigns (see below).

- *Public Education Campaigns:* This review illustrates that there is a huge need for government to invest in better knowledge for patients and their health care providers. In addition to training RMPs a public education campaign would play a useful role in health care delivery. A health awareness campaign could cover the potential hazards of visiting RMPs as well as general information on illnesses that the rural poor are likely to experience and their successful treatments. Such a program, if successful, could create a demand for improved needle protocols and reduced use of drips, steroids and antibiotics etc. Community mobilization and public

[41] Chakraborty 2000.
[42] Ibid.

education components could easily be built into PHC contracting out arrangements and indeed have been an integral part of the successful pilots in Andhra Pradesh (see section V).

- *Social Franchising*: Franchising is traditionally used in the private sector to expand outreach of a certain product, and capture economies of scale whilst also ensuring a high product quality. These characteristics make it particularly suitable for improving access to health care especially health care that can be packaged as a product. Involving RMPs in a franchise scheme has a number of advantages. It can train the RMPs to provide useful services such as family planning products and advice. It can build on an existing grass roots network that is already well-established and respected in rural areas. The Janani experience in India illustrates that outreach through an RMP franchise scheme can be rapid and effective. However, the current model also illustrates that such a program faces greater difficulties in trying to reduce the inappropriate responses of RMPs. Government's role in such a scheme could be to support the public good elements such as an awareness campaign or through a subsidy to the franchisors. A separate background paper to this study provides more detail on the social franchising model and the Janani experience.

Reducing costs

Out-of-pocket expenditures are estimated to finance approximately 70 percent of health expenditures. As shown above, paying for health care, in such a manner, often pushes families into poverty. Reducing costs for the poor could simply involve increasing government spending allocations to the sector. There is plenty of evidence that public health care budgets in India are extremely low, woefully inadequate to address current challenges and completely incongruent with the current national strategy and coverage targets. However in the past, increased allocations to health have simply gone on new hiring and increased salaries to health workers who are often absent from their posts. Increasing spending in the absence of reform is therefore unlikely to have a significant impact on health outcomes.

Policy Recommendation 4 – Promote sustainable and affordable health insurance

An alternative method to reduce out-of-pocket expenditures is to establish affordable health care insurance for the poor or medical savings accounts (see section IV). Expanded coverage of successful insurance scheme pilots might go a long way to pool the risks and overcome the reluctance of the poor to come forward for in-patient treatment. However, such an initiative is fraught with difficulty. Government has made several vain attempts to establish such a schemes in the past as section IV illustrates. Unfortunately government schemes are prone to political interference and mismanagement. It is suggested that the delivery of health insurance should be left to the private sector and that government should focus its efforts on improving the regulation and enabling framework.

It is suggested that government analyzes existing risk pooling and health insurance schemes. Such an analysis should form the basis for a new strategy aimed at mobilizing more resources for health on a prepaid basis, pooling them, allocating them effectively, and using payment and purchasing methods to achieve priority health goals. A start has been made in this regard and the initial findings and key challenges are presented in section IV more details are found in the background papers especially the state-level reviews of Andhra Pradesh and Karnataka. Further work in this area is being undertaken by a World Bank team and the results of this research will be available later in 2004.

Strengthening health care financing includes development of the health insurance market and risk-protection schemes. The agreed emphasis on strengthening health insurance must be based in a larger

health system financing strategy, which addresses the government's overall goals of improving health outcomes, is logically consistent, and fiscally and administratively sustainable. The development of a health financing strategy requires sound information and evidence and would include:

- *Health Public Expenditure Review (HPER):* An HPER will improve the evidence basis on the flow of funds with the public system, and should include a public expenditure management review, to understand at which levels and according to which criteria decisions concerning allocation of public resources for health are taken.

- *National Health Accounts (NHA):* are needed to better understand the flow of funds within the health sector, including private sources of financing and private providers. The beginnings of a system of health accounts has completed in some states including Karnataka.[43]

- *Development of a medium term fiscal plan for health (MTFP):* is needed as a means to develop strategic financial planning, and to use health financing tools in a well-planned and focused way to improve the priority outcomes set out for the health sector.

Areas for further research

This paper has provided an overall assessment of the current and potential role of the private sector in health care delivery for the poor. It points to the potential benefits that will come as a result of improved government stewardship over the whole sector followed by contracting for primary health care, facilitating the introduction of financially sound insurance and social franchising schemes.

The background papers provide more detailed information that would be required by government officials interested in piloting such schemes. However, there are several issues that are beyond the scope of this paper that deserve to be studied in further depth including;

- *Private Sector Survey:* This paper has drawn on existing surveys of the formal and informal private sector in selected states. A more extensive effort is required to assess the size, scope, charging, services delivered, quality control mechanisms etc. of the private sector.

- *Understanding success:* While the public sector in most Indian states has failed to deliver quality health care to the poor, it has succeeded in certain states such as Kerala and Tamil Nadu. Health care stakeholders are undecided on the reasons behind this success. A study examining the reasons behind these successes could point the way to improving public sector health interventions in other states.

- *Piloting insurance schemes:* As illustrated by the study, although several pilot insurance schemes have been attempted by both the public and private sectors none have successfully addressed the needs of the poor in an equitable and sustainable manner. Further action-oriented analysis i.e. the formulation of a successful pilot scheme would represent a major breakthrough in this important area.

- *Analysis of social franchising:* Although social franchising schemes have been shown to be tremendously successful in extending outreach of basic family planning products and services, to date there is no robust cost-benefit analysis that would determine whether such schemes represent the best use of public resources.

[43] District Health Accounts: An Empirical Investigation, V. B. Annigeri Economic and Political Weekly 2003.

Annex 1 : Poverty in India

It is estimated that approximately 29 percent[44] of the Indian population live below the poverty line. However, using the internationally comparable standard of the proportion of people living on less than $1 a day, the poverty rate for India was 39% in 1999/2000. Although India has made significant progress in reducing poverty, (down from an estimated 36 percent in 1993/4), there remains a considerable challenge. In order to meet the Millennium Development Goals, India will need to reduce the number of people in poverty by an additional 123 million people by 2015[45].

Table A1- Selected Statistics pertaining to child health care among the BIMARU states.

			% of children			
State	Infant mortality rate	Under-five mortality rate	Age 12-23 months who have received all vaccinations[46]	Under 3 years under-weight	Under 3 years stunted	Under 3 years wasted
Bihar	72.9	105.1	11.0	54.4	53.7	21.0
Madhya Pradesh	86.1	137.6	22.4	55.1	51.0	19.8
Rajasthan	80.4	114.9	17.3	50.6	52.0	11.7
Uttar Pradesh	86.7	122.5	21.2	51.7	55.5	11.1
India	**67.6**	**94.9**	**42.0**	**47.0**	**45.5**	**15.5**

(Source National Family Health Survey, India 2002).

In order to set the context for the study and focus it exclusively on the poor, it is useful to briefly review some of the social and demographic characteristics of the poor. This section reviews the following factors that impact health outcomes of the poor; geographic location, economic characteristics, gender inequalities, educational attainment, health status, ethnicity and access to clean water and improved sanitation. Readers who are familiar with the Indian context may skip this section.

Geographic location

The poor are primarily concentrated in the northern region of the country, primarily in the states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh (BIMARU) the total population of these states is approximately 366 million. Over 80 percent of this population lives in rural areas, where there is a high dependency on the land and agriculture as a source of income. There is also a large variance of wealth between these poorer states and the richest states in India, Bihar has a GDP per capita of approximately $85 and Delhi, the country's richest state, has a GDP per capita of approximately $600 This illustrates the wide variance between the states in terms of income levels and standards of living.

[44] World Bank, "Country Assistance Strategy Progress Report", January 15th 2003.
[45] Population in poverty in 1990 was estimated at 347 million.
[46] BCG, measles, and threes doses each of DPT and polio vaccines.

Economic Characteristics

The poor live overwhelmingly in rural areas where they are engaged in agriculture, either as laborers or working their own land. Many of them lack any type of material assets to use in case of emergency and tend to have very limited access to institutional sources of credit. All these factors, combined with limited public spending on health care, put the poor at a high risk of not receiving adequate health care for their ailments. Statistics show that over 40 percent of hospitalized Indians are forced to borrow money or sell assets to cover their expenses, and of those who are above the poverty line, 25 percent fall into poverty as a result of their hospitalization[47].

Gender Inequalities

Women are typically more disadvantaged than men in terms economic status, based on their lack of education and "triple burden" of child caring, housework and labor. Women are often considered to be part of the household's dependency burden, since many of them earn less for their unskilled labor than men. Women are also disproportionately impacted by the poor state of the health care system, the maternal mortality rate is approximately 410 per 100,000 live births, which puts India in the highest category of maternal mortality rates in the world.

Illiteracy

Illiteracy rates in the poorest regions of the country are above 60 percent, much higher than the national average of 43.5 percent. Illiteracy hinders the ability of the poor to become socially and economically mobile. Illiteracy among women is higher than it is for the men in every area. "Spending" (foregone wages) on education for women is not seen as beneficial since many of them are married young and the education would only benefit their husband's family not their own. On average, illiterate women have more children, do not immunize them and have a higher rate of disease prevalence. Improving female education will improve health outcomes.

Scheduled casts / Scheduled tribes

Studies on scheduled casts and scheduled tribes (SC/ST) indicate that they are more prone to fall below the poverty line than other segments of the Indian society. Of the SC/ST households, 65% are below the poverty line. SC/ST's also have higher rates of infant and child mortality, malnutrition and morbidity. In addition to this, SC/ST also have the highest fertility rates in Indian society, which only increases the financial burden on this group.

In Uttar Pradesh, SC/ST comprise less than one-quarter of the population yet continue to account for one third of the poor in that state, which furthers the assumption that social identity is a strong predictor of who is and is not poor. "Lower castes often live on the fringes of rural villages, often distant from public services such as schools, health centers, public hand pumps, and shops that distribute subsidized grains, in principle all services meant to assist poor families"[48]. There are reports that show that even if SC/ST members have access to public facilities, they are often discriminated against by upper cast members who control these facilities.

[47] Peters et al « Better Health Systems for India's Poor » page, 5.
[48] World Bank "Poverty in India – The Challenge of Uttar Pradesh".

Access to water and Sanitation

Access to clean drinking water is a critical element to reduce the spread of diseases, such as cholera and diarrhea. According to UNICEF statistics, only 84 percent of the Indian population has access to "safe water", that leaves approximately 164 million people vulnerable to water borne diseases. It would be safe to assume that a large portion of this population falls below the poverty line and is located in rural areas where basic utilities have yet to reach many communities.

Only 2 percent of the Indian population have access to adequate sanitation. Recent studies in the country, also show that there is a large variance between rural and urban communities in access to adequate sanitation. According to a recent World Bank study, of the poorest quintile in the rural areas, only 9 percent of the households had a latrine in the dwelling compared to 31 percent for the wealthiest quintile. This is a sharp contrast to the similar group in urban areas where the poorest quintile 71 percent of households had a latrine in the dwelling and 94 percent for the wealthiest quintile in the urban communities[49].

Alcoholism and Tobacco Use

Alcohol and tobacco use are high risk factors for cardiovascular disease. National Sample Survey data show that throughout India, alcohol and tobacco use is higher among the poor than the non poor, which puts the poor at a higher level of risk for cardiovascular disease than the non poor. It also makes them more susceptible to other related diseases such as cancer, and liver disease.[50] This is a trend that is on the increase in many rural areas.

Box A1 : Effective Technologies to Combat Communicable Diseases

The following drugs and technologies are highly effective when used correctly:

- Antibiotics for treating pneumonia are 90 percent effective. Cost Rs 15 per course
- Oral rehydration for treating dehydration due too diarrhea is highly effective. Cost: Rs 20 per dose
- Measles vaccine is 85 percent effective in preventing measles. Cost: Rs 12 per vaccination
- Tuberculosis medicines are 95 percent effective in curing TB. Cost: Less than Rs 500 for a six month course
- Antimalarials are 95 percent effective. Cost Rs 6 per course
- Bednets, by reducing mosquito-borne malaria, can reduce child deaths by 25 percent. Cost: Rs 200 each
- Latex condoms are highly effective at preventing HIV. Cost: Rs 650 for years supply.

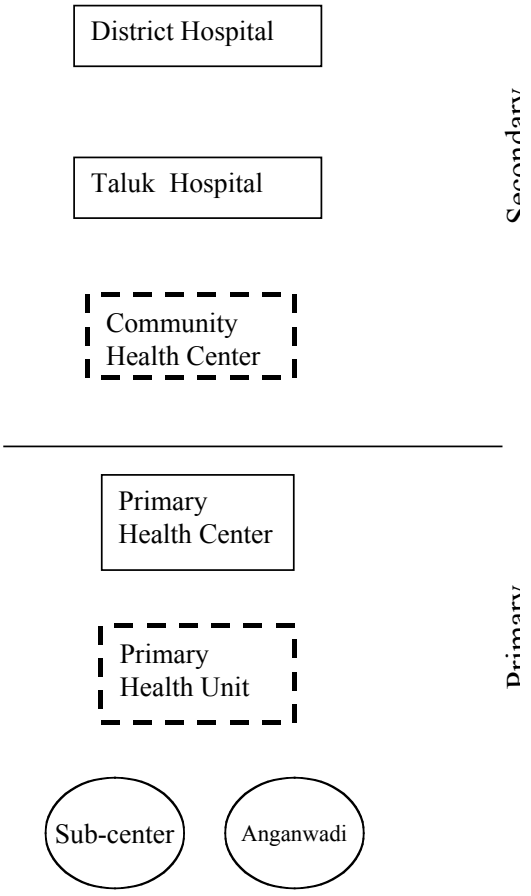
Source: WHO, also quoted in India Raising the Sights World Bank 2001.

[49] UP/Bihar Poverty Study, page 54.
[50] Peters et. al, Better Health Systems for India's Poor 2002. p208

Annex 2 : The Public Primary Health Care System

Public primary health care in rural Karnataka is centered around the Primary Health Center (PHC). Karnataka currently has 1,685 PHCs and 583 PHUs. The PHC is intended to serve a population of 30,000 with smaller populations in the more remote rural or hilly areas and larger populations covered in urban areas. However, due to political interference in the site selection of PHCs, their distribution is uneven and needs to be rationalized to reflect closer the actual needs. Occasionally, PHCs are also accompanied by smaller Primary Health Units (PHUs), also called Additional PHCs in some states, however, they have been phased out gradually or upgraded.

Figure 1 : Health Care Structure



The PHCs are hubs for 5-6 sub-centers that each cover three villages and are operated by an Auxiliary Nurse Midwife (ANM). In addition to the sub-centers which are often no more than the ANMs quarters, village level primary health care is also supported through a network of anganwadi (nursing) centers that offer free nutrition and child care to children between the ages of 3-6 years.

At the higher levels the state is aiming for a community health center (a 30-bed hospital) for every 4-5 PHCs. Each of these CHCs is expected to include at least one physician, one general surgeon and one gynecologist and would cover a population of at least 100,000. At the moment there are 249 community health centers in the state (1 per 220,000).

A comparison with other states in India illustrates that Karnataka matches or does slightly better than all-India averages in terms of population covered by public primary health facilities (see Table A2.1). However, there are several states such as Kerala and Tamil Nadu that have a higher number of facilities at the lowest levels of the health care system.

It is clear that health facilities in Karnataka are more concentrated at the higher levels of the health care system with fewer sub-centers to each PHC and more CHCs per PHC. However, it should be noted that the number of sub-centers under each PHC is determined by population norms and that simply increasing the number of facilities alone is unlikely to contribute to improved health outcomes for the reasons explained below.

Table A2.1 : Rural health infrastructure, selected Indian states

		Karnataka	Andhra Pradesh	Kerala	Tamil Nadu	India
Average area covered (sq.km)	Sub Center	23.03	25.54	6.97	14.27	22.89
	PHC	117.13	202.18	36.98	86.27	136.22
	CHC	774.88	1,303.93	443.76	1,720.58	1,154.82
Area radial distance (km)	Sub Center	2.71	2.85	1.49	2.13	2.70
	PHC	6.10	8.02	3.43	5.24	6.58
	CHC	15.70	20.37	11.88	23.40	19.17
Area number of villages	Sub Center	3.32	2.52	0.27	1.82	4.29
	PHC	16.91	19.91	1.44	11.02	25.54
	CHC	11.84	128.43	17.30	219.75	216.53
Number of Sub Centers per PHC		5.09	7.92	5.31	6.05	5.95
Number of PHCs per CHC		6.62	6.45	12.00	19.94	8.48
Ratio of Female to Male MPW		1.62	1.32	1.36	4.62	2.09
Av. Population covered by ANM / Female MPW		3,837	4,466	4,748	4.305	4,707

Source: Rural Health Statistics in India, 1998 : Bureau of Health Intelligence, GOI.

Table A2.2 : PHC absentee rates per state

	Doctors	Non-Doctors
Andhra Pradesh	45.8	32.3
Assam	45.7	60
Bihar	66.7	49.7
Chhatisgarh	40.3	18
Gujarat	41	52.9
Haryana	46.7	39.8
Jharkhand	56.5	41.3
Karnataka	38.2	41.6
Madhya Pradesh	28.2	27.5
Maharashtra	29.9	30.3
Orissa	32.5	29.4
Punjab	38.8	43.8
Rajasthan	45.8	36.7
Tamil Nadu	57	33.5
Uttar Pradesh	46.2	41.8
Uttaranchal	52.1	39.6
West Bengal	38.8	34.6

Notes: The absentee rate is the percentage of providers who are supposed to be present but are not on the day of an unannounced visit. *Source*: Provider Absence Project Research Team, World Bank 2004

Annex 3 : Rural Medical Providers (RMPs)

Every village has at least one or more Rural Medical Provider. Some states make a distinction between those that are registered and those that are not. The latter are often, pejoratively termed "quacks". As none are qualified to practice medicine and there is little difference between those that are registered and those that are not – this paper makes no distinction between them. These individuals are either doctors qualified and registered in traditional Indian medicine such as Ayurvedic medicine, or have no formal medical training at all. In rare cases, some RMPs group are subsidized by donors, NGOs or wealthy philanthropists but the vast majority survive by charging for their services. The profile of the typical RMP below is derived from visits to more than a dozen RMPs in Karnataka, Bihar, Punjab and Andhra Pradesh.

Equipment: In general, RMPs operate from a single rented room, often living in a room above or adjacent to the clinic. The only equipment that is commonly found is a patient's chair or bench, a stethoscope, blood pressure gauge, and syringes. Closer to urban areas, RMPs will sometimes have an additional room where intravenous drips are administered, while some have the ability to carry out urine and/or blood tests. All RMPs visited had a telephone and connection to the electric grid (although power supply was extremely erratic, no more than a few hours per day, in most areas) but none had a refrigerator.

Qualifications: About half the RMPs that we visited were registered and qualified in Ayurvedic medicine. One was a qualified MBBS doctor and the remainder had no formal qualifications or training. The ayurvedic doctors are able to provide ayurvedic services but they report there is little demand in the village for such treatments. One RMP in Hubli district attends an annual refresher course in ayurvedic medicine for which he pays Rs500. The course is provided by a union of 400-500 ayurvedic operating in the area. Despite their lack of qualifications in allopathic medicine all RMPs practiced allopathic medicine largely in response to popular demand. Among those with no formal qualifications some had inherited the practice from their fathers, others had "learnt the trade" working in PHCs or private nursing homes. The Supreme Court has ruled that any person practicing in a medical system in which he/she is not qualified is a quack. The vast majority of RMPs fall into this category.

Medical practices: Patients visiting an RMP typically come with aches, pains, fevers, diarrhea or vomiting. RMPs also care for pregnant women and report giving them tetanus immunizations, hematonic tablets and calcium. All RMPs report that the public want to see a doctor and get an injection that will provide an instant cure. Failing that, they are prepared to take tablets but few will leave if they have only been given counseling and advice. RMPs agreed that perhaps 90% of patients are given an injection following the consultation and the charging structure is such that they only pay for the injection and not the consultation. Only one of the RMPs we visited was actually qualified to give injections (an MBBS doctor). The others were practicing varying degrees of what the Supreme Court has termed quackery e.g. injecting through clothing, not using clean needles etc. The most common injection given was a Vitamin B12 complex, little more than a placebo to satisfy the demand for injections. However, all the RMPs also administered a variety of anti-biotics and steroids and one of the unqualified RMPs also offered intravenous saline solutions. RMPs displayed a variety of attitudes to needle protocols ranging from reportedly using disposable needles, to boiling needles in hot water. Some RMPs use the same syringe and change the needle while others do not bother changing either. Even those that did follow sterile procedures were not able to dispose of their needles in an appropriate manner.

Referrals: RMPs refer their patients to the local PHC or Taluka hospital if the latter is nearby. Sometimes they are paid a "finders fee" by private nursing homes. The cost of the bus journey to the local PHC varies between Rs10-Rs20 depending on location. It is also reported that patients would have to pay at least Rs5 in informal payments per visit at the PHC.

Popularity: In the absence of regulation, such providers have been allowed to prosper. Even small villages of between 6-10,000 inhabitants often support two or more RMPs. Adapting flexibly to demand some RMPs visited two or more villages during the week. Villagers stated that the reasons for using RMPs include; the practice is open at convenient times (RMP practices are usually operated from 8am – 1pm and then again from 6pm –10pm), those in which the RMP lives on the premises are open all the time, RMPs are prepared to make house calls on elderly or incapacitated patients, and the RMP is often of good standing and well-known in the community and treats patients with kindness and respect. Another attractive feature is service provided on credit to those who cannot afford to pay immediately.

Cost Structure: There are little or no capital costs involved in starting up such a practice. The consultation room can be rented for Rs150/month while a further Rs300/month secures reasonable accommodation. The RMPs source their drugs from private pharmaceutical companies. Sometimes they receive a bonus (either cash payment or free samples) based on drugs ordered from the company. The unit cost per injection comes to approximately Rs1.2 while commonly dispensed tablets such as analgesics cost Rs47 per 1,000. The saline drip, administered approximately once a month, is charged at Rs50-Rs100 and costs Rs40.

RMPs in rural areas typically charge Rs10-20 per visit with the understanding that the consultation is free and the patient only pays for medication. RMPs in semi-urban areas tend to charge more. All practitioners report offering free (or reduced price) services for the very poor and higher charges for those that wish to jump the queue (usually Rs30-Rs50). Demand for RMPs varies a great deal between particular provider, we estimate that each RMP treats between 20 to 50 patients per day providing a comfortable monthly income of between Rs8,000-Rs20,000.

In the long term, once every village has access to effective medical care, these RMPs or "quacks" will gradually disappear. In the short term. it is important to differentiate between those that can play a productive and useful role in health care provision and those that should be barred from continuing to practice medicine or at least ignored by the health system if it proves impossible to close them down.

Some suggestions on RMPs

- *Undertake an in-depth survey of RMPs*: Although this brief study has shed some light on the operations of the average RMP, it is not enough information from which to draw strong conclusions. A representative facility survey of such private practices would reveal the illnesses treated, medical practices, training levels, tariffs and reasons for high demand.

- *Consider franchising or accreditation*: RMPs are currently unregulated and although their operations are illegal it is impossible to shut them down. An alternative method of improving quality is to accredit those that go through basic training either publicly or privately provided. Training at the very least could cover safe needle protocols. Accreditation can also take the form of social franchising whereby selected RMPs are reoriented to provide health care products and services that require limited training to deliver effectively.

- *Public education*: The majority of RMPs are quacks often offering a cure that may be worse than the illness. The public need to be informed that such injections, saline drips and tablets offered by non-qualified practitioners are at best useless and at worst may expose them to HIV/AIDS, hepatitis and other diseases. A related public education campaign could increase awareness of the most serious illnesses and provide information on their treatments.

Annex 4: Community-Based Health Insurance (CBHI)

Funds in Rwanda increase utilization and reduce financial barriers to access health care[51]

As part of the national effort to rebuild the country, the Government of Rwanda was interested in promoting innovative strategies to generate additional resources to fund health care services. In Rwanda, public health centers and hospitals earn the majority of their revenues from user fees which imposes a financial burden on patients at the time of need. As a result, utilization of formal health services is low and people delay obtaining care until they are very ill (Schneider et al., 2001). An additional result is that there are insufficient funds to operate health services which results in drug stock outs and unmotivated staff. CBHI was the strategy tried in Rwanda to address the issues of low utilization, lack of financial protection, and insufficient resources to fund health services. The MOH chose to test community based prepayment schemes in three districts using an approach that involved community members in design, management, and oversight. This experience has been well documented and evaluated by Pia Schneider and colleagues using study and control districts and before and after comparisons and contains valuable lessons for design, implementation, and management of community based prepayment schemes in resource poor settings.

In the first year of the pilot study, starting July 1999, 54 prepayment schemes were initiated that enrolled 88,303 members representing 8 percent of the population of the three districts (Schneider et al., 2001). In exchange for an annual premium, families could obtain access to all preventive and curative services and drugs offered in their chosen public health center and to a limited package of inpatient services from the district hospital. Hospital services were covered only if the patient had a referral from the health center. By prepaying for services at a time that households had income, and after a one month waiting period, families were able to insure themselves against large out-of-pocket payments for services throughout the year. One result was that new case consultations for members were up to five times higher than for non-members. Strong improvements in the utilization of preventive services were also a result. Immunization rates increased 50 percent, prenatal care 25 percent, and there were 45 percent more assisted deliveries among the covered population (Schneider et al., 2001). Rather than being interpreted as a moral hazard effect of insurance leading to excessive utilization, these results were interpreted as eliminating the gap between needed and obtained health services that existed before the introduction of community based health insurance (Schneider et al., 2001).

With the introduction of CBHI, each of the 54 health centers in the three pilot districts became a partner that offers one prepayment scheme. Families that enroll choose their preferred participating public health center. Each month, scheme managers retain 4 percent of premiums for administration; send 4 percent to the district hospital fund that pools risks for the district and manages funds to cover hospital services for members; send 49 percent to health centers to cover capitation payments; and retain 43 percent in bank assets to cover future payments (Schneider et al., 2001). Health centers receive a monthly capitation payment for each member who enrolls with them. Hospitals are paid by the district federation per episode for cesarean sections, malaria treatment and non-surgical pediatric cases and fee-for-services for consultations and overnight stays. By the end of a year, 7 percent of premiums were spent on administration, 7 percent on hospital services, and 86 percent on health center level care (Schneider et al., 2001).

As part of the evaluation of the impact of the pilots, the MOH wanted to understand what population groups chose to enroll in the community based insurance schemes and whether membership improved

[51] From Marek et. al. Resource Allocation and Purchasing in Africa forthcoming.

financial access without increasing the overall burden of out-of-pocket spending. To answer these questions Pia Schneider and colleagues estimated three demand models using household data (Schneider et al., 2001a).

Results indicated that the probability of purchasing insurance was not determined by health need or economic factors but by the level of education of the head of the household, family size, district of residence, distance to the health center, and radio ownership. The income quartile of families was not shown to be significant and cattle ownership, an indication of household wealth, was also insignificant. The second model looked at the determinant of use of services and found that members used up to five times the number of curative and preventive services than non-members. The probability of a visit decreased with distance to the health center and increased with severity of illness, but those with coverage sought care when less sick. Results from the third model found that annual per capita contributions of member are up to five times greater than payments by non-members but payments at the time of service are significantly lower for members. This indicates that the presence of insurance changed care seeking behavior of members causing them to access care more frequently and sooner."

Annex 5 : Improving public sector management of health facilities

There are many different ways of potentially improving the responsiveness of the public health care system. In general the most successful methods will involve changing the incentives embedded in the system for providers to offer quality health care to the poor. This annex introduces a number of suggestions for the primary and secondary sectors.

Improving primary health care

Increasing budgets: Increasing the budget will only provide more of the same failures unless also accompanied by strategic reforms. Paying absentee doctors a higher salary will not improve health outcomes. Although facilities in many states could be improved with additional resources, again without a rational, demand-led plan for the location of such facilities, without a maintenance budget or performance system, improving facilities alone is unlikely to bring about the targeted improvements in health outcomes. Increasing user-charges is likely to be counter-productive at the primary level as it would deter the poorest from approaching PHCs and exempting the poor can be difficult or costly.

Improving incentives: A reform of the system could alter the incentives for performance and health outcomes. A comprehensive reform would start with a consideration of the health challenges in each state and work backwards to possible solutions. However, a partial reform to improve PHC functions could be contemplated. It would start with an examination of the current PHC norms and ask;

- Does it make sense to have a doctor at the PHC?,
- Does it make sense to have the same number of ANMs per population in every state given that birth rates differ dramatically from state to state?
- Does government have the capacity and funds to adequately maintain and operate the current level of infrastructure?
- How can government attract doctors to the rural areas?
- How can the Panchayati Ray play a bigger role in oversight of PHCs?

Attracting health care workers to rural areas: Methods to increase the incentives for qualified health care workers to locate to rural areas need to be explored. These could include; (i) upgrading the role of the Auxiliary Nurse Midwives (ANMs), (ii) requiring trainee doctors to spend 1-2 years of their training period in rural areas, (iii) introducing diploma or "barefoot" doctors, (iv) altering the selection criteria for medical college to encourage more individuals from rural communities to qualify, (v) introducing a small user charge for the non-poor, (vi) increasing the salaries of doctors working in the rural areas and/or (vi) simply improving monitoring and enforcement mechanisms in the public sector.

Measuring performance: Unless it is measured, there is no incentive to improve performance. Although this seems obvious, the performance of PHCs is not measured or benchmarked against state-wide norms. Punjab state government has demonstrated that simply by measuring and publishing performance statistics, government can have a significant impact on improving efficiency and effectiveness within the public health system (see background paper on Punjab).

Alternative payment methods: The current system whereby health care workers are paid regardless of work completed does not provide any incentive to deliver quality care. Effective alternative payment methods would include schemes whereby part or all of the public health care workers salaries depended on care provided and allowed the poor to choose between public and private providers to create competition within the system (see background paper on international case studies for a good example of using vouchers to strengthen demand for care for sexually transmitted diseases in Nicaragua).

Improving secondary health care

Recent experience in improving secondary health care in Punjab illustrates that successful reforms within the current system are possible.[52] The Government of Punjab recently embarked on a process of corporatizing their secondary health facilities. The policy implications of the Punjab experience are;

User charges: Introducing user-charges in a transparent and accountable way, while excluding BPL individuals, can provide an incentive for secondary hospitals to increase utilization, especially if revenues are used at the point of collection. Even a modest charge can significantly expand the maintenance and equipment budget and provide increased flexibility and responsiveness at the facility level.

Introducing a Health Management Information System: can provide timely and accurate information needed to improve management of public facilities. A good HMIS gives managers the ability to monitor inputs and outputs of the system and helps assess the costs and returns from various procedures. Measuring performance and distributing that information automatically provides an incentive to perform.

Outsouring non-clinical functions: Out-sourcing non-clinical functions especially sanitation has resulted in much cleaner hospitals (evidenced by independent patient surveys) as a far lower cost. It has also resulted in reliable ambulance, telephone and canteen services.

Customer satisfaction surveys: Another potential way of addressing this situation is to introduce customer satisfaction surveys. If doctor's salaries and/or promotions were linked to, amongst other things, the outcome of such surveys they would have a greater incentive to provide care to the poor and treat them courteously. As a large segment of the rural poor are illiterate they would not be able to complete written questionnaires. Perhaps the feedback could be collected through periodic random exit interviews by independent assessors and a number of public sector patients. Alternatively the assessors could visit a representative number of poor individuals in the community to avoid self selection. Although such surveys can be expensive, preliminary experience in Punjab has shown that they can have an impact on service delivery and quality.

Improving voice: Health outcomes can be improved, if local communities have a greater input into the provision of public health care. At the moment, in most states, the local Panchayati Raj system of oversight is not working as the health management committees are not functioning or are not representing the poor. Even when they are working, the local health committee has no authority over the medical staff, whose salaries, transfers and promotions are controlled at the district and state levels.[53] Improving decentralized administration and oversight would improve responsiveness.

Citizens' Charter: An alternative method to stimulate improved services is to educate the public about their rights. Each PHC can post a patients' bill of rights. They could also be asked to post a list of charges for services and a list of drugs that are not currently available thereby eliminating the practice of extracting additional payments to procure drugs that health workers claim are not available. Government can consider these cost-effective schemes to increase the transparency and responsiveness of the system.

Complaints line: Another related idea is to institute a complaints bureau or build on the role currently being played by the Lokayukta. This function could improve responsiveness and reduce corruption, providing the political will to support such an effort were forthcoming. Karnataka is a particularly good example of where this has worked well.[54]

[52] See Punjab: Health Sector Assessment , a background paper to this study.
[53] Celia W. Dugger. New York Times March 25th 2004.
[54] For more on this see Anuradha Rao, "Karnataka Lokayukta Initiatives in the Public Health Sector", May 2003.

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