HEALTH CARE UNDER FISCAL CONSOLIDATION

The meaning of the 2013- 14 Health Sector Budget in the context of the debate over the 12th Plan- and the notion of Universal Health Coverage

Public Health Resource Network

Building Capacities for Public Health Action

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Question 1:

Does the health sector budget for 2013-14- give a 24 % increase as mentioned in the finance minister's speech? The 12th Plan made out a 300% increase over 5 years- or a 60 % increase per year. What has happened in the first two years of the plan?

a. The increase in budget allocation for health sector in 2013- 14 as against 2012-13 is a mere 8.2%. The increase in NRHM allocation is even less- a mere 2%.

	Budget Allocated 2013-14 (in crores)	Budget Allocated 2012-13 (in crores)	Budget Allocated 2011-12 (in crores)
Total to MoHFW	37330.00 (8.2%increase of over previous year)	34488.00 (12.8% increase of over previous year	30456.00
NRHM[1]	18880.35 (50.5% of total allocation)- (2% increase from previous year allocation)	18515.35 (53.68% of total allocation) (14.7% increase from 11-12)	16140.76 (52.48% of total allocation)

b. The 2% increase in NRHM allocation does not even compensate for inflation- meaning that in real terms there is a decline in allocation.

c. Further the Finance Minister (FM) in the budget speech categorically states that the allocation is to National Health Mission (NHM), which is an expansion of NRHM. NHM has five components of which three are pre-existing in the 11th Plan- the NRHM-RCH flexi-pool, the flexi-pool for communicable diseases and the Central Family Welfare component. The two new components are the national urban health mission, and a flexi-pool for disease control programmes. The ministry had asked for Rs. 3200 crores for the urban health mission and for Rs. 1500 crores for non-communicable diseases for 2013-14. But with a 2% increase- either one has to cut-back existing programmes, or fail to start these new programmes.

d. Further a NHM under the 12th Plan has to provide for the following schemes

[1] National Rural Health Mission

i. Free essential drugs and diagnostics in government hospitals- at least Rs. 2000 crores in the first year and at best Rs. 6000 crores per year in the last year of the plan. Most states have announced these programmes, but now the money is no longer there.

ii. Strengthening district hospitals- at least Rs. 20 crores per hospital or about Rs. 1200 crores.

iii. Pilots for Universal Health Care- this too required at least Rs. 50 crores per district and for 30 districts would require about Rs. 1500 crores. This too has had to be shelved.

e. The FM in his speech stated that there has been a 24% increase over the previous year. But what he was referring to was the revised estimate. Revised estimates are almost always lesser than budget allocations. This year in particular, as part of a drive to reduce fiscal deficit, the budget allocation had been reduced to Rs. 17,000 crores revised estimate. This is despite the fact that the department was well within what is the accepted rate of expenditure. It is important to appreciate that this revised estimate is not because of the inability of the health department to absorb funds. It was because of a deliberate policy of tightening on all expenditures. Thus many states did not have their last installment released, meaning that an unannounced budget cut has already been put in place.

f. Further, even on release of this there are a number of pressures exerted. One mechanism of tightening expenditure lies with what is called internal finance divisions of ministry which jointly report to the department of expenditure. One of the most common mechanisms this uses is to blame failure to release on non-receipt of utilization certificates for earlier installments. But to quote one instance, a state's last installment of Rs. 500 crores was withheld because though they had submitted UCs for most of their money, there was still an amount of Rs. 2 lakh given for a telemedicine project many years back. This was a debt that NRHM had inherited even though there had never been a telemedicine component in NRHM, though none of the current officers knew about it. In good times Rs. 2 lakhs would have been held back and the rest of the money released. But now it was a convenient excuse for stopping all of the Rs. 500 crores. Many clearances for release are given on the last day or too late for the releases to take place.

Question 2:

What are the Stated reasons for reducing allocation- and the facts?

a. Stated Reason: There is the allegation that the health department and NRHM in particular fails to use its funds.

   - Fact: This is not true. Expenditures have been above release after 2008. In the first few years of the NRHM it took time to build capacity, but this is not the case any longer.

b. Stated reason: That there is no value for money. The outcomes are not proportional to the expectations or expenditure.

   - Fact: Claims are in fact modest. The MOHFW claims that only about one-thirds of the targets are met. But the funds released are only one thirds of the envisaged funds under the approved framework of the NRHM- about Rs. 66,000 crores released against Rs. 175,000 crores envisaged. Similarly funds released under 11^{th} Plan are less than half of what was the Plan outlay. The physical achievements are proportional to this.

   - Fact: When a target for service delivery was set, the goals were for every PHC to become a 24*7 PHC and every CHC to become an FRU. This of course did not happen. But there are 2500 FRUs todays where there were 950 in 2005. There are 12000 24*7 facilities today where there were less than 3000 earlier. This level of achievement has been attested to by every evaluation carried out, whether by international agencies, or by national agencies, both external and internal. The increases in out-patients, in-patients, deliveries and procedures are well documented. Acceleration of health outcomes in terms of TFR, IMR and MMR as measured by annual percentage decrease is also well established.

   - This is not to deny that there are gaps and that quality of care has not risen at the same rate. However this is clearly not the reason for the slash of the budget.

c. Stated Reason: That the government has to reduce government expenditure in order to reduce fiscal deficit. This is called fiscal consolidation and it requires that all Plan consumption expenditure be reduced. This is unfortunate but essential as reduction of fiscal deficit is needed for economic growth and that is the priority.

- Fact: Fiscal deficit can also be reduced by raising more tax revenue. Yet industry has been given tax exemption the total value of which is estimated at Rs. 530,000 crores. The most modest expectations of the health ministry were only for an additional Rs. 10,000 crores. Its maximal expectation was for another Rs. 30,000 crores. Some of the tax exemptions could easily have been avoided. There is no fiscal crisis similar to the early nineties. There is every reason to believe that the cut in expenditure was deliberate and by choice, with neither any administrative nor economic consideration as the basis.

Question 3:

What are Consequences of the reduction of the health budget?

The consequences of this cut-back on financing are going to be:

a. The public share of total health expenditure that had inched up from 18 % of total health expenditure to 29% of total health expenditure, or from 0.9 % of GDP to about 1.4% of GDP, will collapse back to less than the earlier position.

b. There would be stagnation of all public health programmes, and even a reversal on key components.

c. The 12th Plan had set a number of targets and raised expectations on expansion of service delivery. While getting the ministry to own the plan, the projection was a 300% increase in plan outlay over the 11th plan outlay. But now with only 20% increase in the first two years of the plan, there is no move to scale down the targets, only an increase in shrillness on the failure to reach targets. Thus a case is being built for declaring public systems as failing and no doubt some or the other instance of corruption would be taken up as evidence to prove this. Exactly what the Planning Commission did with respect to the 11th Plan.

d. This would lead to a further growth of privatization of health care- what could be called passive privatization- leading to huge Out of pocket expenditures and impoverishment for the people, poorer health outcomes for the people and greater profits for the corporate.

Question 4:

How do we understand this cut in budget in the light of the HLEG report and the 12th Plan document? Budget cuts in health care are rare. Even at the height of the fiscal crisis, actual budgets did not decrease as the finance minister has now done. But what is astonishing is that such a cut comes in the background of a lot of talk about how the 12th five-year plan is going to be a 'Health Plan' with its focus on health. When work on the 12th plan began, the nation was given to expect that 2.5% of GDP allocated to health was almost a certainty. With great disappointment it was reduced to 1.84 % and the justification given was that even after such reduction it would mean a 300% increase over the 11th plan outlay.

There was also this constant talk of Universal Health Coverage. The Planning Commission set up a High Level Expert Group to examine this very issue, and after a highly publicized exercise, they came out with a voluminous report. Most of its key suggestions are incorporated in the 12th Plan document.

Given such a background, it makes the cut in budget astounding. How does one understand this?

a. The High Level Expert Group made some very useful points, especially as regards to the reduction in user fees, moving away from selective health care to comprehensive health care and from a system where only BPL was eligible for free care to where almost everyone was entitled to cash less care. It also recommended increases in health human resources, and increased role for communities and a regulatory framework that covers both public and private sector. Interestingly it also pointed out the problems in purchasing care on a fee for service basis through insurance mechanisms and identified it as inherently faulty.

b. However the High Level Expert Group report had three major weaknesses, and this was to be its undoing. Firstly, it refrained from pointing out the reasons why the public system was under-performing, especially the roots of this in the health sector reform introduced under World Bank tutelage and neo-liberal theory in the early nineties. The introduction of user fees, the shift to selective care, the reduction in human resources and the targeted BPL approach were part of this and knowing this would have made us cautious about further neo-liberal theories, which it inadvertently adopted as its framework of analysis. Secondly, it failed to apply any creativity or innovation on measures to improve public health systems, falling back into notions of competition and choice. And thirdly as a solution to the problems of purchase of services on a fee for service basis through insurance it recommended purchase on a capitation fee basis of health

plans from what it called integrated provider entities, but what were in reality thinly disguised corporate run managed care entities. On the NRHM and how to improve it, the HLEG remained largely silent, allowing for underestimation of the role it was playing and the need for building up on it.

c. The Planning Commission's utilization of the HLEG report for the 12th Plan was patchy and very superficial except for the para 3.1.10 that called for purchase of care from "an integrated care provider entity". In a draft version of the 12th Plan, it spelt out clearly how it interpreted the HLEG report. It declared that the public service of delivery is inherently both inefficient and of poor quality since there are no material incentives of a salaried work-force to improve performance. And therefore UHC must necessarily mean a slow switch over from public service delivery to purchase of care from large networks of independent care providers.

d. The argument that public sector is inherently inefficient is far from the truth. Today though public health expenditure accounts for only 20% of total health expenditure and accounts for only 20% of the medical workforce, it provides for about 20% of all out-patient care; (33% of all qualified out-patient care), PLUS about 40% of all in-patient care, including about 60% of all hospital based critical pre-terminal care, PLUS about 100% of all preventive and promotive care. The truth is that even with this meagre increase in investment that NRHM represents, the public health expenditure as a percentage of total health expenditure rose from 18% to 30% in the last 5 years for which data is available.

e. This is not to hide the terrible inadequacies of the public health system but to point out that the main problem is not with the fact that it is built around a salaried workforce which has no incentives to improve services, but that there are problems of investment and institutional frameworks and capacity. Another problem underlying poor performance is poor governance, but this would affect equally if not more, the problems of purchase of services.

f. It is worth noting that the July draft of the 12th Plan chapter- did not get approved. It was seriously resisted by the Health Ministry itself and from civil society, notably the Jan Swasthya Abhiyan and this opposition was well reflected in the media debate on the same. Bowing to a clear opposition from the Minister, the doors for large scale auction of health blocks to managed care corporate entities was abandoned and the central role of the public health sector was reiterated in the final version of the 12th five year plan.

g. But with the doors temporarily closed on such active privatization, the policy options turned back to strategy of the nineties- passive privatization. The entire 90s saw a systematic cutback in public expenditure and a liberal opening up of

private sector. It saw hospitals forced to impose user fees, public health care systems in most states failing to hire staff even to replace retiring staff and withdrawal of free drugs and diagnostics, and the failure to add any more public sector beds. Theoretical expectation was that the private sector would grow to close the gap. The private sector grew, but in a skewed fashion, largely urban, and supply driven services. People were forced to resort to private care and the cost was impoverishment and the absence of a safety net for the poor.

h. The slashing of the budget 2013-14 has similar aims. The only explanation for why after so much talk of raising budgets and universal health coverage, the budget was actually cut is that this talk had all along really been about corporatization and opening doors to public financing of private providers such that a few of them could build up a monopoly in the form of large integrated provider entities. Prevented from doing this, the next best option was to scuttle public health systems so that it did not provide an alternative to the costly private care. All this talk about free drugs and free care had basically not been about providing it free in the public sector, which anyway the 11th plan had already stated, but making it free for some chosen private providers as well.

Question 5:

Does this lead to the Planning Commission re-scheduling its targets and deadlines? If with 300% increase, the goal for IMR is from 43 to 25, does it now say that for a 100% increase over 5 years, the target is raised to 35? Does the elite public health community, largely financed by international agencies point this out and demand a more reasonable estimate of results?

Far from it- their silence is deafening. On the other hand there is already pressure from the Planning Commission on why targets are not being achieved and using this so called non achievement to allow space for corporates to enter in the name of innovation for more efficient delivery of services.

Question 6:

What could democratic organisations and concerned citizens do?

The task of people's health movements must be to convince states that investment in health will benefit people and that electorates will recognize this. There is one major difference between fiscal consolidation and fiscal crisis. This time around there is money but there is a conscious decision not to provide it for "plan spending related to consumption". There is also huge tax foregone to the amount of 4.6 lakh crores in 2010-11 and 5.31 lakh crore in 2011-12. Had these giveaways been withdrawn there would have been no fiscal deficit at all! The minimum increase that the public health sector needed to keep up its strengthening process was just another Rs. 10,000 crores this year, a miniscule and negligible percentage of the huge tax foregone. Underlying the cynical calculus behind this budget cuts for health is also the perception that where NRHM is doing well, the state governments are benefitting more than the ruling party at the center.

And whatever the merits of purchasing from the private sector may be, with the limited resources available, the only way forward is to invest it in better organized public service delivery. And even for this state governments have to take the risk and increase state expenditures on health. TN and Kerala did not become best performing health states because of central support. They became best performing despite it- because they maintained their levels of public investment all through the nineties- when other states faltered, in part due to the fiscal crisis. This time around, these other states need not.

Question 7:

But is there such a possibility for corporate control? Are there grounds to apprehend that corporate health care industry wants a stunted public health system? Why now?

There are some major changes in the health care industry scenario in India after the global recession of 2008. For one, health care industry was one of the few industries that were relatively recession proof. In India health care industry grew rapidly and this is now perhaps the second fastest growing segment of Indian industry. There are no caps on FDI (foreign direct investment) and FDI has been flooding in. To quote: "Forty-eight transactions with a cumulative value of about $1.23 billion last year (2012) made the healthcare industry India's second-largest sector for investment after the information technology industry, according to

a report by PricewaterhouseCoopers. In 2011, the healthcare sector in India had attracted investments worth $418 million spread across 38 deals, PwC said. This growth comes despite global private equity's hesitance to deploy their capital in India, across sectors, given the prevailing political uncertainty and ongoing regulatory opacity in the country. Overall, private equity investments in India fell 15 percent to $8.85 billion" (Reporting by Suzannah Benjamin in Bangalore, Editing by Saumyadeb Chakrabarty)[2].

There are many instances of rags to riches. For example: Vikas Mulye's fund, ICICI Venture sold its stake in diagnostic chain Metropolis Healthcare to Warburg Pincus for 3.92 billion Rupees, a 10-fold return on its 350-million-Rupee investment in 2006.

Or take the history of Vasan Eye care, hardly a significant player till 2006, now with 150 hospitals and 30 plus dental clinics it calls itself the world largest eye care provider. It received 100 million dollars of FDI last year and about 10 million dollars the previous year (Its start-up capital is a source of mystery and indeed some of those who speculated on its ownership in blogs were arrested).

Industry sources discussing what they call "the bright spot in private equity market" find one major source of resistance or constraint on their growth[3]. To quote:

"The biggest challenge will be convincing patients such as Chandrashekhar Khandke, a 30-year-old software professional at IBM in Pune, who said he has visited modern clinics a few times but still prefers his family doctor. "If I buy grains from a grocery store or from a supermarket, it doesn't make much of a difference but when it comes to health, a family doctor matters a lot," he said.

Overcoming the draw of a trusted doctor may prove harder than it seems, even in a country where healthcare infrastructure is poor. Electronic medical records are rare, and the quality of doctors and other medical professionals is patchy."Although branded clinics have potential, they find it tough to pull patients from a strong local doctor. Also, if there is a big hospital in the vicinity, then they lose out on patients," said Deepak Malik, analyst at Mumbai-based brokerage Emkay Global Financial Services Ltd.

While fees at modern clinics range from 150 to 600 Rupees for treatment of routine illness, sole general practitioners charge patients anything between 50 and 300 Rupees per visit.

"While these chains have a unique brand, a trusted doctor is even a bigger brand," said Anil Advani, a doctor who operates an old but modest 800-square-foot (75-square-metre) clinic in Thane, outside Mumbai.

What we are witnessing is a struggle between the unorganized highly market-competition based numerous small providers who come in the way of health care industry controlled by big capital and its desire for monopoly. Such monopoly is essential to increase the rate of return on investment, for much of this is venture capital, which demands the highest rates of return. This is not dissimilar to the debate around FDI in retail with this important exception. In health care industry there is already no cap in FDI but what corporate power

[2] http://in.reuters.com/article/2013/02/26/orbimed-fund-idINDEE91P0DF20130226

[3] http://ns.bdnews24.com/details.php?id=238924&cid=4

seeks is that some of them are publicly financed on a per capitation basis so that they can give free care and so that those who do not join in at terms that the owner of the integrated care provider entity would offer, would be pushed out of the market. This would be further backed by a strategy of quality assurance and regulation so that those who do manage to survive this unequal competition on trust of patients could be closed down on grounds of quality of care.

Therefore, though the industry and its spokespersons in the government establishment may declare that it is poor quality of care and a failing NRHM and government inefficiency that is the cause of budget cuts, the truth is actually quite different.

Parallels are not difficult to seek. For example in the coal industry Coal India was set targets that it could never achieve and against its own wisdom. Then it was neither given the investment nor the leeway to expand and meets its own objectives. Finally on the basis of the fact that the public sector was not performing the coal blocks were auctioned. Most of the buyers did not bother to extract coal. They preferred to sell it, or keep it dormant till prices were better. As we know it now, the sales were largely to cronies and the government suffered a huge loss and the cause of power generation was not helped. The government defense was that this was not a loss but was the system at work.

Similarly if like the coal blocks, health blocks were sold off, as the July draft had indicated; and if the integrated care provider had spent only half the money, he would be entitled to the rest as financial rewards and profits for the shareholders and this would be legitimate and be calculated as a part of public health expenditure. This is the same way payments to insurance companies are counted today, and is the form in which corporatization is being introduced in India. But if public financing is not available in a big way, the interim measure is to keep the public system small and discredited so that at the next big opportunity, it can be re-launched.

Question 8:

But how could the HLEG have supported such a plan? Surely they meant something else when they talked of Universal Health Coverage. After all a distinguished panel of eminent public health persons discussed this and came up with this quite independently. So this air of conspiracy – is it merited?

What we need to note is the growth of Universal Health Coverage as a concept. In 2005 it had passing mention in a WHO resolution. In 2008 it was a closing chapter, one amongst many in the WHO report. In 2010 it had become the entire WHO report and in 2012 both

WHO and UN had adopted a resolution mandating this as the main goal. Between 2008 and 2012 all international health agencies had aligned with this goal. Rockefeller Foundation played an important role in providing the support to global governance and public health institutions and academics to align with this goal and in a sense coordinated the shaping of this agenda.

It is worth noting that almost simultaneously many nations of the world had similar moves towards Universal Health Coverage and prepared similar high-level reports. Even the NHS in UK was undergoing restructuring on similar principles and all of it was opening the door to corporatization. There are remarkable similarities in the reports. All of them talk of purchase through capitation fee based health plans as the main goal and equally important confess that such a scheme is not really operational on scale anywhere, except for managed care in the US, but therefore in all countries pilots are recommended to test the coordinated care provider, the managed care provider, the integrated local care provider or some similar entity. Is it just a coincidence? Is it also a coincidence that in 2008 the global recession was at its peak and global capital was needed fresh areas of investment?

Now the HLEG makes approximately 65 + recommendations of which only about 40+ makes it to the executive summary, of which only para 3.1.10 is cited as such in the 12th Plan report. In a box on HLEG some relatively unimportant recommendations are also cited. Most members of the HLEG were unaware of the true import of para 3.1.10 and not more than three or four members could have been involved in its rather explicit wording. Even with respect to this para 3.1.9 makes some sort of escape clause by which the recommendation in 3.1.10 is diluted if not negated. On such a slender basis of support, has the HLEG report been used to open the gates to corporate control of primary health care? So slender is the link that one would have dismissed it, except that in a recent book “Plot Against the NHS” the details of similar changes that were introduced in to the UK health care system is described in considerable detail. It makes us think.

Question 9:

What should be a peoples’ response to this dangerous drift in health care policy? We know industry, having been thwarted of plan A will now move onto plan B. What are the peoples’ movement responses post the 12th Plan and the 2013-14 budgets taken together not as a contradictory process, but as different forms of manifestation of the main direction of policy change being thrust on the nation?

a. The first and foremost step is to demand for more public investment in health care and oppose this slashing of the health budget. The reasons provided by the

state for cutting down the health budget should also be firmly rejected and the true reason, that it is meant to help private sector growth, should be exposed.

b. Without excusing the problems of access and quality of public health care, there is a need to ensure that the criticism of public health systems does not become a justification for its corporatization. For this the critique of public health care has to be well grounded and well-focused such that the true reasons of poor performance and the sources of poor governance are exposed. The accountability paradigm is necessary but not sufficient to critique what ails the public system. The larger question is really of institutional design and capacity and the relationships of power embedded in them. Other than that, another central reason is a deliberate withholding of investment whenever there is a danger of improving its performance.

c. There must be a good coordination between those working within the public health system and those working outside it to not only improve its functioning but also educate the public on the true causes of its poor performance. An important part of this goal is to give voice to peoples' demands as perceived by them in coordination with the problems as perceived by the workforce so that they synergize and reinforce each other. Pitting the public against the provider-worker in any form is mischievous. However it is important to isolate the enemy within and its coordination with the enemy without. Measures against equity in health care, measures that promote or participate in relationship with conflict of interests and in corruption are the entire enemy within and those working within would need to distance themselves and isolate them. Similarly, civil society groups, often funded by international donor agencies and corporate agencies take to positioning themselves as the peoples voice to unfairly discredit public systems. They too pose a similar problem.

d. The fourth necessity is a good watch on the private sector since anyway no one else is doing it, and bringing to public notice and the notice of decision makers with integrity, their plans, aspirations and directions.

e. The fifth and most important is to draw up clear road maps of where we are in the path to universal health care and what specific investments and programmes are needed to reach there. These are best done in the form of district health plans with clear costing of what it takes to provide additional services and what institutional changes are needed for a pro-people, pro-poor health care. This could go along with clear constructive suggestions of what changes in policy and strategy are needed to strengthen NRHM as a vehicle of financing the strengthening of public health service delivery in the states and the achievement of health outcomes.

Public Health Resource Network (PHRN) seeks to identify like-minded, motivated individuals and organisations through existing state level resource support agencies, NGO networks and state health societies, and reach out to them in order to accelerate and consolidate the potential gains from the National Rural Health Mission that can truly change the health scenario of disadvantaged people. PHRN has been active since 2005 in the states of Bihar, Chhattisgarh, Jharkhand, Rajasthan and Odisha. It has also supported similar action in many other states, such as Rajasthan, Haryana, Uttarakhand and the North Eastern states. PHRN has refined its objectives and strategies in accordance with its experience as well as circumstances of its work.