NSSO 71st Round Data on Health and Beyond

Questioning Frameworks of Analysis

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The overarching policy question in private expenditure on health that we should all be addressing is, "What must the government do to reduce the debilitating (financial) effects of out-of-pocket healthcare expenditure of people?"
A response to a comment (EPW, 21 November 2015) on the authors' earlier piece (EPW, 15 August 2015).

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In response to our earlier commentary on the National Sample Survey Office's (NSSO) 71st Round (EPW, 15 August 2015), Nishant Jain et al (in short, NASK in EPW, 21 November 2015) have engaged in an important and valuable debate on the interpretation and policy implications of NSSO 71st round data. The specific objectives of our commentary were to (a) illustrate the usefulness of the NSSO's 71st survey to policymaking process in health, (b) cull out evidence on the out-of-pocket (OOP) spending on health and on the "inadequate coverage" through government schemes, and (c) suggest ways to improve our "evidence" base in the future.

The overarching purpose was to emphasise the urgent need to reduce the overwhelming financing risks on the people, particularly on the poorer sections of the country, arising out of increasing OOP expenses made towards healthcare. The policy question we should all be addressing can be put as follows: "What must the government do to reduce the debilitating (financial) effects of out-of-pocket healthcare expenditure of people in India?" We presume, NASK would not be in disagreement with this formulation of what we consider as "one among the most critical policy questions" that we should address in the Indian context.

In this piece, we shall (a) clarify some our earlier observations and (b) advance further evidence and arguments (which are partially in the nature of a rebuttal to NASK) in support of the important policy question mentioned above.

Critical Issues

Let us first address the critical issues:
(1) We begin with two issues which have been raised that directly relate to NSSO data and its methodology. We note that the categorisation of self-care as medical treatment makes no difference to comparability of prevalence rate, nor to choice of provider. Self-care accounts for only around 12% of all episodes of care within the last 15 days. The average medical expenditure changes only marginally when we exclude self-care, increasing from Rs 609 to Rs 668, but this still amounts to a significant increase over previous rounds. Comparability therefore is quite possible and the changes have no immediate implications for the issues under discussion.
(2) We do not agree that collection of information incurred on treatment based on a "paid" approach instead of a "payable" approach *limits* us from being able to comment on cashless health insurance. Indeed, our whole contention is that a "cashless health insurance as (where) no money is paid by households from their pocket in these cases" is almost in the nature of a myth. The NSSO 71st round data does allow us to examine whether households which have insurance coverage and are aware of it experience cashless service or even significant degrees of financial protection in terms of OOP expenditure as compared to those who have no insurance coverage. The authors are correct in stating that an attribution of reimbursement directly to the patients as the only measure of effective coverage is flawed. We clarify that the low levels of reimbursement made directly to clients are useful only to state that the expenditure being counted as OOP expenditure is not altered significantly by such reimbursements. In Table 1 (p 86) we show the differences in "net" "paid" OOP expenditure after deducting any such reimbursements. There are many clarifications that need to be made regarding Table 1 such as the relationship between income categories and nature of insurance coverage, the significance between mean and median, but that all of these would only further reiterate our central point that there is a major difference between nominally covered by (registered in) a cashless insurance scheme and effective coverage (proportion of those who are registered, required hospitalisation and

got significant financial protection). Let alone cashless care, in publicly financed insurance schemes, the difference in net OOP expenditure experienced between those with insurance cover and those without insurance seeking private healthcare is too limited to be considered as meaningful financial protection.

Table 1: Average OOP Expenditure per Hospitalisation by Provider Type and by Different Insurance Categories in Last 365 Days
(excluding hospitalised deaths)

Scheme	Provider	Mean (Rs)	Median (Rs)	N
Government-funded insurance scheme (ex RSBY, Arogyasri, CGHS, ESIS, etc)	Public	2,817	900	4,030
	Private	18,081	10,200	4,235
	Total	10,943	3,550	8,265
Employer supported health protection (other than government)	Public	4,301	1,250	260
	Private	19,441	7,200	566
	Total	15,463	5,600	826
Arranged by household with insurance companies	Public	11,596	1,500	91
	Private	19,688	8,000	814
	Total	19,188	7,450	905
Others	Public	2,608	2,000	52
	Private	14,106	5,250	120
	Total	10,842	3,700	172
Not covered	Public	4,560	1,402	21,833
	Private	22,912	11,500	23,025
	Total	14,436	5,100	44,858

OOP expenditure includes all medical expenses and patient transport. N is the actual sample size without weightages. Costs of care are calculated with weightages.
Source: Authors' computation from unit records of NSSO 71st round.

Assessment of Insurance

(3) The NSSO 71st round is *not* an evaluation of the insurance schemes. But it does draw attention to this wide gap between nominal coverage and effective coverage and this is consistent with most other evaluations of government-financed insurance schemes (Selvaraj et al 2015; Ghosh 2014; Nandy et al 2013). It does indicate the need for a great caution to policymakers before they invest more in insurance schemes as compared to investing in public health services—which on the other hand show a clear protective effect. We would, in line with the draft National Health Policy 2015, call for a re-conceptulalisation of public provisioning of healthcare services as a form of tax-paid insurance or prepayment whose efficiency, quality and accountability need to be improved. To the extent that publicly-funded insurance is going to be essential to engage the large private sector and supplement public sector provisioning, the message from NSSO 71 and other evaluations is that we need to show greater concern about accountability in the private sector too, and not have any naïve belief in markets and individual choice being able to attend to this. Much higher degrees of government intervention and institutional capacity are required.

(4) NASK agree that "from a patient's out-of-pocket expenditure perspective, the net outflow is much lower in the public hospital than in the private ones." However they argue that "while the cost to a household in a public hospital does not represent the full cost of service, the outgo at the private hospital represents the true opportunity costs of availing the medical services. This is so because of subsidies built into public healthcare delivery such as salaries of doctors, and paramedical staff, cost of land, building, equipment, etc." The implication is that if all costs are counted for, it would be equally (or more?) efficient to provide financial protection through purchase of care from private sector. We had limited ourselves to the patients' perspective, as this is the meaning of financial protection and this is what the NSSO data can comment on. But now that NASK have raised this question, let us point out some of the problems of this contention with regard to efficiency. First, many private sector hospitals also receive public subsidy in terms of land costs, equipment, tax concessions, not to speak of subsidised medical education, etc. Second, more importantly, public healthcare systems provide far more than hospitalisation care. We know that of total health expenditure, roughly 28% is public health expenditure (2010), and the rest is mainly OOP expenditure. But this 28% that government spends on healthcare covers 28% of all rural outpatient care, 21% of all urban out-patient care, about 42% of all rural inpatient care, 32% of all urban inpatient care, about 70% of all institutional delivery in rural areas and 40% in urban areas, and almost 100% of all preventive and promotive care services (which includes a very wide basket of public services such as immunisation, vector control and disease surveillance), and in addition, also covers a substantial portion of medical and nursing education and yet other functions like the medico-legal.

We therefore would like to argue that "the expenditure on health care by governments (union and state) has increased by more than four times in nominal terms, but the share of patient load for hospitalised care in government facilities has remained practically static in rural areas (41.7% to 41.9%) and steadily decline in the urban areas between the 60th and 71st round survey" is quite misleading. The correlation that NASK make between the recent increase in public health expenditure and the stagnating public share of hospitalisation misses this understanding altogether. A rupee spent in an insurance scheme buys a rupee worth of hospitalisation. A rupee spent as public health expenditure buys a large bundle of public goods of which subsidy on patient care is a small part. This is not said in praise of the public services, but it acknowledges the need for much greater public investment.

Private v Public Expenditure

(5) The NASK commentary almost exclaims: "it is quite inexplicable why households across income group choose to go to private hospitals despite the expenditure on private hospital being over four times that of public hospital." Let us reiterate and elaborate the explanation we had earlier suggested.

We had noted earlier that a major driver of this increased public expenditure was through the National Rural Health Mission whose focus, even on health systems strengthening, was largely on improving delivery of select reproductive and child health (RCH) services (Draft National Health Policy, 2015 or NHP, paras 2.6, 2.7, pp 6 and 7), and within this in improving institutional delivery. Therefore the main positive finding in the survey is the dramatic increase in institutional deliveries, from 36% a decade ago to 80% now. Why would we expect any increase in urban areas when the increase in public expenditure was only for rural areas? We know that the Urban Health Mission was launched only in 2013 and by 2014, when this survey was

conducted, it was only in the very early stages of implementation and without any significant increase in the resource envelope. And why would we expect a general increase of in-patients even in rural areas, when there is no significant increase in resource allocation for trauma care or for non-communicable disease or for communicable diseases other than those three or four diseases which are part of national disease control programmes? What we measure as outputs must correlate with what the government spent on and intended to do. Otherwise, it represents not a mere analytical slip, but a gross error in assessing the value of public programmes and exposes lack of even simple heuristic ability expected of policy analysers.

(6) NASK do take note that this "remarkable success of National Rural Health Mission in ensuring that 80% of all deliveries in the rural areas are now happening in a hospital or a health center compared to 36% a decade ago, and that government hospitals account for 70% of the overall deliveries in rural areas" but then go on to state "that maternity incentive programmes like Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakaram (JSSK)—offering cash incentives to women and Accredited Social Health Activist (ASHA) workers for incentivising institutional deliveries in government hospitals, may not apply and might not even be fiscally prudent or sustainable for a wide range of healthcare services." There are several problems with this line of argument. The JSSK is a programme that finances public facilities for improved quality of delivery services in healthcare facilities and reducing OOP expenditure on such care. It is *not* an incentive paid to either ASHAs or pregnant women. The JSY is a demand-side financing effort, but as one major evaluation of JSY showed (NHSRC 2011), it is best understood as an effort that helped improve access by overcoming the financial barriers to seeking care and by bringing pressure on public systems to provide these services. This evaluation also showed that though much reduced, there was still significant OOP expenditure, even in public facilities, which is a finding reiterated in NSSO 71st round as well.

The ASHA incentive is a performance-based payment made for her providing a package of services. Most sources would agree that the ASHA is severely under-paid for the wide and varied work performed by her and that the bulk of any income she gets in most states is only from the so-called JSY incentive. Most political and civil society voices have called for a regular and higher level of payment to her for these services. But in the ideological framework of analysis, such payments get labelled "as lack of fiscal prudence."

The NSSO 71st round data cannot speak on whether investment should be in the form of incentives to ASHAs or through paying premiums to insurance companies for purchasing care from private sector. We only drew attention to this modest correlation—that in the preceding seven years, the government invested its money in providing assured delivery services in rural areas—and the data shows an increase in rural areas. The government did not make investment in urban areas or in non-communicable disease and the NSSO data also shows no significant increase in government provisioning in these areas. It is true that the NRHM framework document talks of general strengthening of all services, but the health sector leadership can reflect on this data to understand better that what was actually financed and implemented was much more selective than what was intended at one level of policymaking.

(7) A policy background to our interpretation is that selective investment in some elements of RCH and communicable disease care and the neglect of the public system is not merely an aberration of implementation or a matter of holding providers accountable. This is the policy design and intent. Since the early 1990s, one continuing thrust in all health sector programmes and in most internationally financed programmes is the insistence on selective healthcare, where government provisioning is restricted to a very narrow and highly selective package of care. To quote the infamous 1993 World Bank Report, "Investing in Health:"

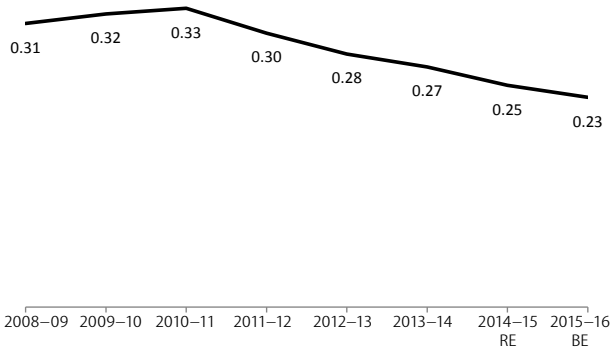
> Beyond a well-defined package of essential services, therefore, the role of the government in clinical services should be limited to improving the capacity of insurance and healthcare markets to provide discretionary care whether through private or through social insurance. Poorer countries must, of necessity, define their essential packages more narrowly (World Bank 1993: 57).

(8) NRHM made some hesitant efforts to reverse this "selective care policy" in its early years, but after the 11th Plan period, it returned even more vigorously to a RCH focus. As different states go into a demographic and epidemiological transition, as non-communicable diseases (NCDs) begin to account for major share of morbidity and mortality, the mismatch between the services prioritised in public healthcare facilities and the needs faced by people are likely to widen. Of the 12 states that showed an increase in private sector hospitalisation in rural, in nine states such a transition has already occurred. This mismatch is true for households in higher economic status also. No doubt, lack of quality contributes to the situation, but so does the epidemiological shift to NCDs and the lack of services to address these at the primary care level, and availability of the full range of services only in grossly overcrowded public mega-hospitals. Selective care must be construed as a passive form of privatisation when the state withdrew from investment, except in a small set of priorities. Can the NSSO 71st round establish this? Certainly not—no more than it can establish that the choice to go to a private provider is a choice made only on quality considerations. But certainly there are enough grounds to consider this framework of analysis, and for policymakers to increase investments in the provision of public primary care services for chronic illness, and for trauma and emergency care.

Rise in Public Health Outlay?

(9) Given the dismal state of public health in India after nearly two decades of structural adjustment-driven health sector reforms, the increase in NRHM was on such a low base line that even after the so-called "four-fold increase" it remains subcritical. All key policy documents, whether it is the National Health Policy draft of 2002 or the draft policy of 2015 or the 12th Five Year Plan or the Report of the High Level Expert Group, have emphasised the need to increase government spending on health to a minimum in the range of 2.5% of the gross domestic

Figure 1: Union's Spending on Health as % of GDP—On a Slippery Slope



Actual expenditure for the last two years are likely to be much less than projected in this figure.
Source: *Union Budget: Expenditure Budget* various years; www.indiabudget.nic.in, accessed on 07.06.15

product (GDP). What this so-called "four-fold increase" represents is an increase in public health expenditure from about 0.9 % in 2005 to about 1.04% in 2011 (Planning Commission, Government of India 2012, Volume III, para 20.3.5: 3). With regard to the NRHM, the National Health Policy 2015 draft admits that "the budget received and the expenditure there under was only about 40% of what was envisaged for a full re-vitalisation in the NRHM Framework" (NHP–2015, para 2.8: 7).

(10) Even this "more than four-fold increase" that is repeatedly referred to by NASK requires a closer inquiry. Our tables for 2005–06 to 2013–14 based on actual expenditures show a much more modest picture of the increase, especially when compared to other macroeconomic parameters like GDP and inflation. (We should take care that central transfers to states are not being double counted—a possible error in such computations.) We are not sure of the exact basis of Table 3 in NASK's commentary. But noting that they provide data for 2014–15, where the actual expenditure figures are not yet available, it could be based on the revised estimates. Actual expenditures tend to be much lower. In Table 2 we show that at constant (2004–05) prices, the increase between 2005–06 and 2013–14 expenditure is just about two times! Further, the major part of the increase is during the early years of NRHM. In the period since 2011, central government expenditures in real terms and as a proportion of GDP have again started declining (Figure 1). The union government's spending on health as a percentage of GDP is the lowest in last four decades, even lower than the early 1990s.

Table 2: Trends in Public Spending on Health by Union and State Governments: 2005–06 to 2013–14

(All figures in Rs crore)

Year	All States	Union	Transfer to States	Total Union and State (Current Prices)	Total Union and State (Constant 2004–05 Prices)
2005–06	23,058	9,650	3,676	29,032	27,776
2006–07	26,765	10,606	2,565	34,806	31,186
2007–08	30,359	14,410	3,464	41,306	34,784
2008–09	36,726	17,661	4,166	50,222	38,792
2009–10	44,610	20,996	4,478	61,128	42,002
2010–11	54,218	24,450	4,984	73,684	45,848
2011–12	67,080	27,199	5,990	88,288	50,709
2012–13	73,217	27,885	6,363	94,738	50,769
2013–14*	86,796	30,135	5,063	1,11,869	54,005

* All figures represent actual expenditures except for 2013–14 where state expenditure which is revised estimate, while union expenditure is in actuals; All states include states and UTs with legislature (Delhi and Puducherry).
Source: All state: State Finance: A Study of Budgets, various years; Government of India: indiabudget.nic.in; *Expenditure Budget* Vol 2, Transfers: indiabudget.nic.in, EB Vol 1.

(11) Where we do not disagree with NASK: We agree that the NSSO 71st round has serious limitations for certain types of interpretations, the need for building a more robust database on healthcare in India, the need to pay greater attention to enforcing accountability, particularly where public money is spent on behalf of the poorer sections of the population, and above all the government's role in reducing the "impoverishing effects" of OOP expenditures on healthcare on the poor in particular.

Conclusions

Clearly there is a need for more careful costing studies to answer questions of relative efficiency and for increasing the quality, efficiency and accountability in both the public and private sectors. Our reading of the NSSO data makes us look beyond the popular myths and stereotypes of times, where people choose private services because of its quality, where insurance will solve problems of financial barriers they face and where the only problems of public services are poor accountability despite the so-called massive investments.

In our framework of analysis what is measured as being delivered by a system best explains what systems are designed to deliver. Public systems are designed and financed to deliver and provide financial protection for a very limited range of services with a limited level of quality and this they do. Insurance programmes could be understood as designed to provide an economic stimulus to both insurance and private healthcare industry (Virk and Atun 2015), while providing a semblance of financial protection. For this it does.

At a time when there is a serious crisis in public health due to falling and failing public investments, an interpretation that is dismissive of the very limited efforts made at strengthening public services or characterises it as fiscal imprudence only serves to justify further decreases of government investment into one of the world's worst-funded public health systems.

We welcome the opportunity to clarify and reiterate our views in these columns.

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