

Policy Brief

Out-of-Pocket Spending on Health in Odisha, September, 2011

Background

A health shock often implies an enormous burden of treatment to an affected household consequently leading to significant erosion of its pre-shock endowment. Globally, an estimated 100 million people are plunged into poverty every year because they have to directly pay for the health services they use at the point of delivery¹. The scenario is particularly bleak in India where market regulation is weak and social protection measures are inadequate. One conservative estimate shows that, in India, about 11.8 million or at least six households in a hundred are silently marching towards poverty every year due to medical care.

The present brief presents some recent evidences on the incidence of catastrophic financial shocks experienced especially by the users of public hospitals in Odisha, one of the eastern Indian states. The scenario is especially interesting in Odisha, where public sector plays a dominant role in providing health care. As the evidences show, despite remarkable increase in public subsidies and a series of initiatives to make public health services affordable and accessible to common people in the state, the strong presence of public sector is still an inadequate instrument for financial protection. Based on recent evidences on Out of Pocket Spending (OOPS) on medical care in the state, the brief intends to highlight the urgency of addressing the problem and bring forth a set of policy options.

Recent Evidences

Based on the NSSO's 60th round data, the Government of India has presented a set of estimates related to OOPS in medical care for all Indian states in its recent report on National Health Accounts. The key estimates for Odisha and India (for 2004-05) are:

- a) Total estimated OOPS on all types of medical care in Odisha was ` 27.55 billion. This was roughly 80% of total health expenditure – much higher than national average of about 71%.
- b) Medicines account for the major share of OOPS in public hospitals (72.6% in rural and 77% in urban areas). This is also much higher than national average (66.5% and 62% respectively).
- c) About two-third (65.4%) of total OOPS in the state (i.e., ` 27.55 billion) was attributable to Outpatient care, followed by 27% to inpatient care, and about 3.4% to birth deliveries. The ratios were more or less the same for all states taken together.

Based on these results, it is estimated that about 5% of all households in the state fell below the poverty line due to health care OOPS seriously challenging the poverty-mitigating and development initiatives of the state.

A recent study conducted on the beneficiaries of public health facilities in 8 districts of Odisha (PHBS 2010) reconfirmed the continuing economic burden of medical care in the state. For example, as the study shows, a hospitalization episode in a public hospital would make a patient pay out of pocket more than ₹ 1000 per day and more than ₹ 4000 for total stay. Similarly, a visit to an outpatient department of these facilities would cost him/her ₹ 180 and even more in districts with relatively higher Human Development Index, such as Balasore, Jagatsinghpur, and Sundargarh. It is also interesting to note that delivering birth at public institutions is also costly (₹ 800 per delivery). The burden, however, is much less on the poorer households implying probable success in JSY financing to BPL families for institutional birth delivery.

Key Issues

The recent evidences (PHBS 2010) also pulled out the following key issues related to OOPS in Odisha.

1. OOPS burden disproportionately higher on users of higher-tier facilities and non-communicable diseases

The burden of OOPS on medical care was found far higher on the users of higher-tier facilities like District Hospitals (DH) than lower-tier facilities (such as, CHC and PHC) for treating the same types of ailments. For example, a person, who sought inpatient care from a DH, would spend about INR 400 less had he/she received the treatment from a lower level facility for the same ailment. The reason behind such cost differential is that the user of a DH is compelled to buy more drugs from private pharmacies and he/she would spend more on travel costs in comparison to a

user of a CHC or a PHC. The additional burden on the users of higher-tier facility for treating common ailments is a product of a weak referral system where the district level secondary hospitals often serve as first points of contact for preventive and basic curative services.

2. Despite increasing public subsidy on drugs, OOPS on drugs is substantially high.

The PHBs, 2010 data showed that more than half of the total burden of OOPS incurred on hospitalized treatment and childbirth under the public system went for purchasing medicines. For outdoor care, this share was just below the half-way mark (Table 1). Spending so high on medicines by the users of government facilities, where medicines could be obtained without cost, indicates that they had to purchase all or some of the prescribed medicines from private pharmacies. For example, out of all currently admitted patients, 86% had purchased medicines from the market. Also 68% of the outpatients stated the same. Also, when asked about the reason of this private purchase, most of them - 53% of the hospitalized patients and 41% of the outpatients had indicated that the prescribed

Table 1: Share (%) of Spending on Medicines in Total OOPS on Health Care, and Average and Aggregate Burden of OOPS on MEDICINES (₹, Current prices), Odisha, 2010

Type	Share (%)	Average Burden (₹)
OOPS till Date on Hospitalization	53%	1,618
OOPS per Non-Hospitalized Treatment	48%	210
OOPS per Childbirth	54%	491

Source: PHBS, 2010

medicines were out of stock in the pharmacies.

Further, the OOPS on medicines was conspicuously high for the users of higher tier facilities, partly because of higher load of complicated cases (which need more medicines) but also possibly due to higher incidence of supplier-induced demand (i.e., doctors prescribing more branded and expensive medicines) in the urban-based district hospitals.

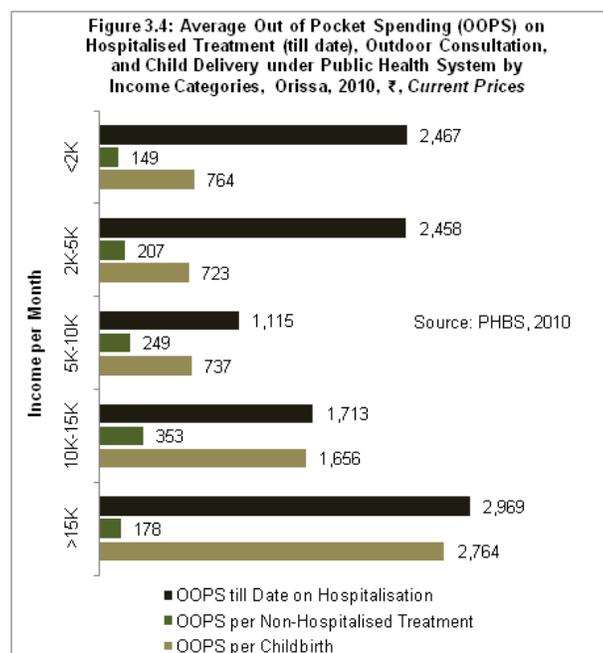
3. OOPS has significant poverty and equity implications

As Figure 1 shows, the burden of OOPS in birth delivery is equitable since the poorer people pay proportionately much less than their richer counterparts. For example, OOPS incurred during delivery of a child in a public health facility by the lowest income category was 72% lower than the same incurred by the highest income group. Perhaps, targeted intervention like JSY – a conditional cash transfer scheme to encourage institutional delivery

- especially among the rural poor - are showing positive signs and poor families are availing cheap but safer routes of institutional deliveries.

But the scenario was just the opposite for the hospitalized cases or outpatient treatment. In both cases, the users spend about the same across all income categories, indicating a serious equity problem – the poorer people are spending much higher percentage of their income compared to their

richer counterparts, making OOPS highly regressive. The consequence could be disastrous especially when a major illness suddenly attacks a member of the household who does not have any protection from risk. A



Manju, a widow from Bolangir district, with one daughter Purnima, earns a paltry sum which is just sufficient for their survival. Her husband died of Sickle Cell Disease and after a series of ailments and consultations with various doctors, the daughter has recently been diagnosed with the same disease.

So far Manju has spent about INR 34,000 on Purnima’s treatment. Her savings from the death benefits of her husband, widow pension, and her own small income are completely wiped out. How will she manage the daily medicine costs?

huge portion of household income drains out and the household slips into deeper poverty.

4. The cumulative shocks to chronic and acute OPD cases are often more catastrophic

An OPD case imposes relatively lighter burden on a household compared to a case of hospitalization. However, high prevalence and frequent occurrence of common ailments make the cumulative financial burden of OPD treatment much erosive than total cost incurred on hospitalized care which affects

only a small percentage of households in a year. This is especially notable for chronic patients who do not require hospitalization but have to depend on regular treatment procedure and are extremely vulnerable to OOPS-induced poverty. A case in point is Sick cell disease which is a major health problem especially in the western part of the state and among tribal population. A case of such disease may invite economic disaster to a family.

Policy Options

The state's health policy, launched in 2002, came up with serious concerns about rising OOPS in the state. However, despite the past and recent reform measures undertaken by the Government of Odisha to invest more in the health sector and to strengthen the service delivery system especially at the public health facilities, the issues related to financial protection of the people from catastrophic OOPS on health care remain largely unaddressed. As mentioned earlier, the recent cash transfer schemes under NRHM, such as JSY, have demonstrated promising progress in this direction; however, the policies regarding OOPS in general inpatient and outpatient care (not related to pregnancy or neonatal care) still remain blurry and unfocused. The only scheme which comes close to address the financial protection issues for general medical care – and that is also only for inpatient care - is RSBY, a centrally sponsored medical insurance scheme for BPL families implemented by the Department of labour and employment.

Given this backdrop, it is important to refocus the issue of financial protection of the users of health care in the state. The urgency of the situation is taken into account by many Indian states with a few visible policy steps. The

following part of this brief lists several policy options for Odisha with the understanding that some of them are already initiated in a small scale. The options are categorized into following four broad groups.

A. Making medicines effectively affordable for public clients

The purpose of this option is to strengthen and supplement the existing drug distribution system at government facilities through some innovative measures. This may be done through

- (i) speeding up the process of *State sponsored or supported commercial pharmacies at government health facilities*, similar to the Lifeline Fluid Stores in Rajasthan, or *Jan Aushadhi Stores* which is already been implemented in Odisha at a small scale.
- (ii) *Streamlining governance of drug procurement and distribution system*, similar to Tamil Nadu Medical Services Corporation Ltd. (TMSCL) which was set up with the primary objective of ensuring ready availability of all essential drugs and medicines in the government medical institutions throughout the State by adopting a streamlined procedure for their procurement, storage and distribution. The innovative measures to streamline drug procurement helped in dramatically bringing down drug prices in Tamil Nadu.
- (iii) *PPP in establishing pharmacies for public users* which implies engaging civil societies (NGOs, self-help groups, cooperatives etc.) in parallel procurement and distribution of drugs. In this context, it would be useful to note the most recent initiatives by the Government of

Rajasthan to make drugs absolutely free for all outpatient users of government hospitals from October 2 this year. Under this scheme, the drugs will be provided free to newly established medicine distribution centres by the government at various government hospitals and selected cooperative institutions will manage these centres.

B. Using RKS more effectively for financial protection

The formal guidelines for the RKS clearly suggest the ways a RKS can use its resources which also include sharing or subsidizing OOPS (e.g., transportation or medicine costs) of poor users from whom lack of money could pose serious problem during service delivery. For example, it can launch voucher schemes for the poorest users to partially or totally pay for referral transports and medicines which are unavailable in the hospital's pharmacy, subject to its financial capacity. Adequate flexibilities should be introduced to the fund approval system to help the local manager take spot decision in urgent cases.

C. Social protection measures for the poor to complement RSBY

There are few deficiencies in the RSBY scheme which makes it inadequate: (1) the families, which are not BPL but bear the risk of falling BPL due to catastrophic expenses, remain unprotected; (2) the scheme covers only inpatient users leaving the risk of gradual impoverishment due to chronic and outpatient care unprotected; (3) since the scheme is managed by commercial insurance companies based on voluntary enrolment, cream skimming or adverse selection may follow implying that the really unhealthy families / persons may not get enrolled; and, (4) without

innovative marketing strategy and active outreach services for registration, the scheme may not reach the poor and uninformed families.

These deficiencies of RSBY may be supplemented with additional initiatives based on experiences from other states, such as *Akshaya Kendras* scheme of Kerala to enroll APL families for the Comprehensive Health Insurance Scheme (CHIS). In this scheme APL families can enroll by paying ` 464 in addition to the RSBY registration fee of ` 30. The enrolment facility is available at over 2000 Akshaya centers across Kerala. Some other states, such as Karnataka and Haryana, are on the way to implement similar initiatives.

The state can also launch its own health insurance scheme following some successful models such as Aarogyasri scheme of AP. In order to facilitate the effective implementation of the scheme, the State Government of AP has set up the Aarogyasri Health Care Trust under the chairmanship of the Chief Minister. The trust, in consultation with the specialists in the field of insurance and medical professionals, runs the scheme. The scheme is totally financed by the state government costing about ` 92.5 billion to the exchequer.

D. Improving oversight

Many policy analysts argue, correction of the systemic deficiency may be more effective and sustainable than compensating the consumers' OOPS through additional subsidies on pre- or post-payment. The most important element in this strategy is to improve oversight at the service delivery level to ensure that (1) the providers do not induce unnecessary or irrational demand of the users, and (2) the leakage and misuse of public resources,

especially those which are directly committed to benefit poor, are controlled.

The concrete step to implement the first element is to frame appropriate regulatory mechanisms to control irrational drug prescriptions at the facilities. The regulation system may be initiated by establishing a task force in the DoH&FW which would collect data on prescribed drugs in randomly selected government facilities in the state, develop a computerized system to feed the data, analyze them on a regular basis, and provide the key policy actors with evidences. It is also to be noted that the Central Government has recently embarked on designing a National Policy for Containment of Anti-microbial Resistance which contains several directions for monitoring prescription behaviour at the facility level. The state can design a state level policy which would align to the national policy and establish an appropriate regulatory framework for the state.

Steps towards an Action Plan

The policy options outlined above are necessarily broad. It is important that the options are debated and discussed amongst the key stakeholders and, based on their feedbacks, a specific action plan is drawn up with an estimated financial implications for each of them. The specific steps towards this direction are suggested below:

- (a) A state level workshop may be organized to disseminate the final draft of this paper and its recommendations. In addition to selected key persons associated with the state's health sector, the workshop may invite several renowned policy analysts from other states. It is expected that the debates and discussions in the workshop will

generate more options and specifics on pros and cons of the proposed options.

- (b) The workshop will also identify 1-2 feasible options and produce an outline of an action plan based on the identified option(s) for the DoH&FW (to take specific policy measures against rising OOPS).
- (c) Based on the feedbacks and the plan outline, a more detailed and specific action plan would be drawn up by DoH&FW within a particular timeline. TMST may provide further technical support to this process.