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Commentary

Financial risk protection & chronic disease care

The rapid and substantial rise of chronic diseases in India – morbidity, mortality and disability – has implications for cost to the government, to the society and to families and individuals[1]. Further, the absence of pre-payment and risk pooling mechanisms, combined with the dominance of market-based health and medical transaction exposes substantial segment of the populations to financial vulnerabilities resulting in catastrophic payments to cover health-related costs[2]. Households end up mortgaging assets, exhausting savings, selling livestock and borrowing funds from private money-lenders at usurious interest rates. According to a recent National Health Accounts (NHA) estimates, India spent about 4.13 per cent of its Gross Domestic Product (GDP) on health care during 2008-2009, while the public health expenditure was only 1.10 per cent of the GDP[3]. Currently, nearly 70 per cent of all health spending in the country comes from the households, while roughly about 70 per cent of all health spending on health care is devoted to purchase medicines from the open market[4]. A recent study suggests that close to half of all households' out-of-pocket (OOP) spending on health care is incurred on non-communicable diseases (NCDs)[5]. Such a magnitude and spending pattern has implications for catastrophic payments and impoverishment of households. Recent estimates suggest that globally nearly 150 million suffer from financial catastrophe and about 100 million are impoverished annually because they need to pay for health care costs[6]. In India, nearly 40 million are impoverished (close to half of all global impoverishment) and a substantial share of the population faces financial catastrophe[7]. A single episode of hospitalization for heart diseases or cancer cases in private health facilities could completely wipe out nearly 80-90 per cent of per capita income of Indians[5].

In this issue, Daivadanam and colleagues report the magnitude of catastrophic health expenditure associated with coronary heart diseases (CHD) and the coping strategies associated with catastrophic spending[8]. A sample of 210 patients suffering from acute coronary syndrome was randomly selected proportionately from six hospitals in Thiruvananthapuram, Kerala. Notwithstanding, a very small sample with unequal distribution of men and women, 84 per cent of the surveyed participants reported catastrophic spending, while the socio-economically disadvantaged reported to be 15 times more vulnerable than their counterparts. Those who suffered job losses and patients with no health insurance protection were likely to report catastrophic expenditure than their counterparts. The study findings confirm earlier literature which suggests that due to acute nature of illness (especially the CVDs,) and the associated spending, households ended up borrowing loans, often resorted to dissaving, while others, albeit a small segment, enrolled into private health insurance schemes.

While prevention and promotional activities are critical in managing chronic care, curative care is equally significant. Governments across developing countries are waking to the realities of health and economic burden caused by NCDs. Not only the individuals and societies are affected, but governments are being/or will be forced to spend an increasingly higher share of their spending on NCDs. However, governments, by virtue of their monopsony power, have the ability to bargain better value for money. Costs controls and economizing scarce resources become absolutely critical in an environment of rising costs due to chronic diseases. Households, on the other hand, must be protected from medical bankruptcies and be provided with financial risk protection.

The last seven years in India, beginning 2005, has marked a significant departure with the past 60 years of health planning and policies, with the ushering in of the government's flagship National Rural Health Mission (NRHM). The period also marks other significant initiatives of both Central and State governments through its publicly-financed health insurance schemes (RSBY, Rajiv Aarogyasri in AP, Chief Minister's Health Insurance Scheme in Tamil Nadu, Vajpayee Aarogyasri in Karnataka, *etc.*). While the avowed intention of these schemes is laudable, its impact has been mixed. Global and Indian experience do not provide credence to these kinds of stand-alone insurance schemes against the emerging evidence. Global evidence is found demonstrating the fact that social health insurance is no better than publicly funded-provided model. The evidence clearly suggests that health outcomes and financial risk protection measures are no better in countries relying on health insurance schemes than in government provided system[9]. A recent study in India clearly demonstrated the ineffectiveness of the publicly-financed health insurance models in providing financial risk protection[4].

Any government policies, plans, and programmes must give primacy to promotive and preventive care. Currently, the publicly-financed health insurance schemes have by design encouraging the growth of tertiary care with utter neglect of primary care. We need to move away from this fragmented and piecemeal approaches to one that calls for universal access to care. The current debate and discussion about the recommendations of the High Level Expert Group (HLEG) on Universal Health Coverage (UHC) therefore, assumes significant national importance[10]. Besides the need to achieve critical health outcomes targets, it also emphasizes the need to provide financial risk protection. The HLEG clearly articulates the need and provides roadmap for rapid and significant reduction in households out-of-pocket expenses. The report of the Steering Committee of the Planning Commission (12th Five Year Plan) also echoes similar views[11]. Clearly the issue of financial risk protection has come to occupy central stage in the health planning and programme process. The only option that is desirable at this stage is to embrace publicly funded-provided model. By ring-fencing substantial share of government spending on primary care, preventive and promotive efforts to chronic care could get lot more attention, which is expected to control costs and economize the scarce resources. This is finally intended to reduce households' OOP expenses and improve health outcomes substantially. Although Kerala's health outcome measures are laudable due to its long-standing focus on primary care, the neighbouring Tamil Nadu appears to have marched ahead of the former, in terms of catching up with Kerala[11]. Besides emphasizing primary care, the successive State governments in Tamil Nadu have provided more focus on strengthening its public health system. Recent initiatives of Tamil Nadu government in designing and delivering effective care for chronic diseases are worth replicating in other States. While treatment of chronic conditions is critical for secondary and tertiary care in the current scenario, strengthening primary care with a focus on preventative and promotive activities is essential for future policy and planning which might be expected to substantially reduce OOP and catastrophic payments to households.

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