Independent People's Tribunal on the World Bank Group in India

PRIVATISATION OF PUBLIC SECTOR HOSPITALS: A STUDY OF USER FEE POLICY IN WEST BENGAL

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USER FEE
OUT OF POCKET EXPENDITURE AT THE POINT OF SERVICE DELIVERY

WORLD BANK
ITS INVOLVEMENT & POLICY ON HEALTH CARE FINANCING

- 1985: Paying for Health Services in Developing Countries (*Working Paper)*
- 1987: Financing Health Services in Developing Countries
- 1993: World Development Report: Investing in Health
- 1995: India Policy and Finance Strategies for Strengthening Primary Health Care Service, Report No. 1304-IN
- 1996: India Health Systems Project II, Report No. 15753-IN
- 1997: India – New Directions in Health Sector Development at the State Level: An Operational Perspective. Report No. 15753-IN

- **2001:** Macroeconomics and Health: Investing in Health for Economic Development, Report of the Commission on Macroeconomics and Health, WHO

- **2005:** Report of the National Commission on Macroeconomics and Health, MOHFW, New Delhi

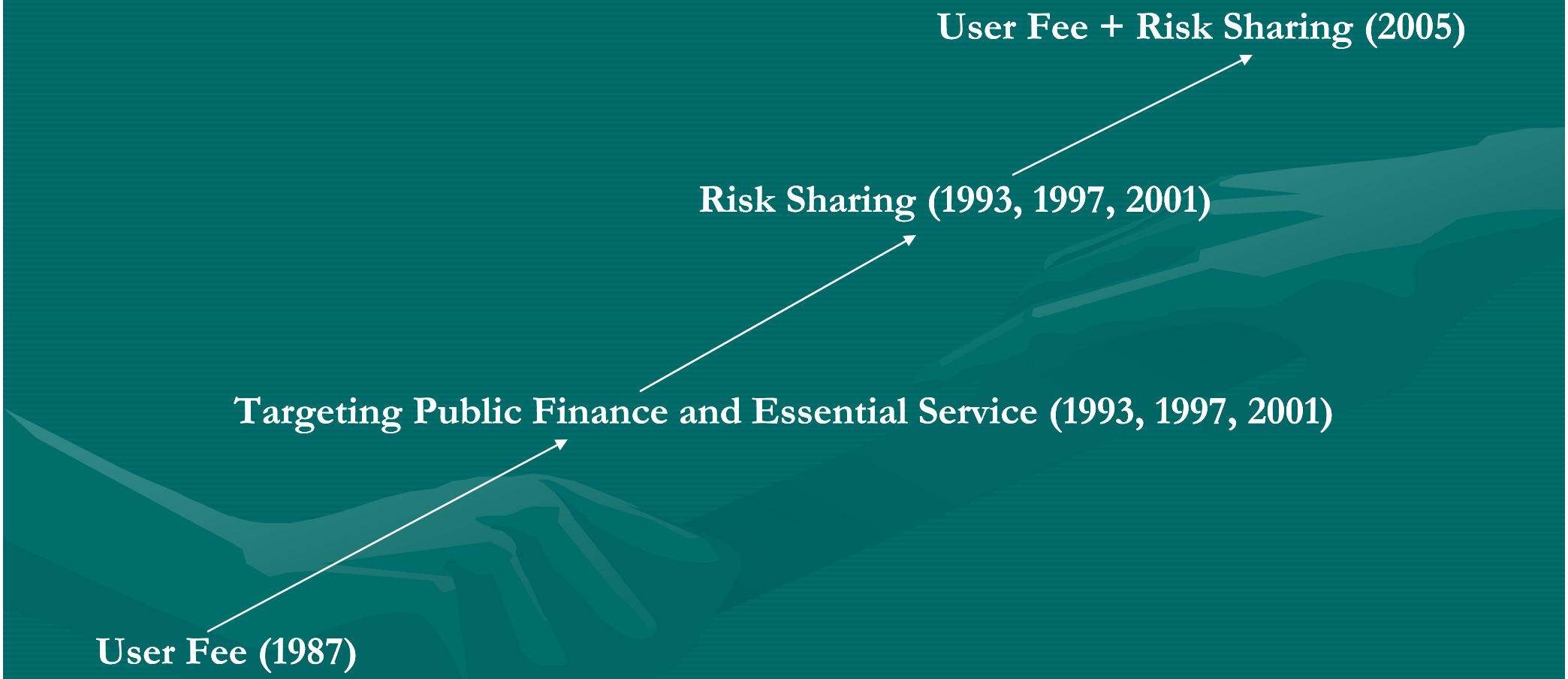
"Introduction of user fees at levels that do not discourage the poor is likely to be more useful for improving technical efficiency(for example by facilitating drug supply) than for raising substantial revenues on a nationwide basis." **(World Bank, 1993)**

"Most of the services in public health institutions are provided free of cost. Nominal charges are levied on only a few services, and revenue collected is deposited the government treasury. The low level of funds normally available is inadequate for supplies, operations and maintenance… … … … …The user fees would be used specifically for non-salary cost purposes, as high proportions of funds collected through user charges would be retained at the point of collection." **(World Bank, 1996).**

- *Community Financing Approach Advocated (WHO, 2001)*

- *"In not levying user fees but promoting insurance, public hospitals stand to lose, as restricted budgets and no access to alternative sources of funds such as user fees and insurance reimbursements, will place them at a distinct disadvantage over the private sector." (GOI, 2005)*

FROM USER FEE TO RISK SHARING



USER FEE IN WEST BENGAL

User fee was there for many years in public sector hospitals (Tertiary and Secondary)

They evolved as means to deals with resource constraint and recover cost

The financial health of West Bengal was worsening and this is of great significance as this determines the investment pattern in infrastructure and social sector

With the introduction of SHSDP II in the state since 1996, World Bank recommended to revise, restructure user fee periodically

In the Nineties user fee was thrice revised (1992, 1995, 1998)

Last user fee revision took place in 2001

The State govt. had prescribed a pre-determined cost recovery rate of 3 to 10 % by the end of 2008-09

Till March 2006, the user fee collected at the source was directly going to the state exchequer

Rogi Kalyan Samiti was formed in April, 2006 and allowed the tertiary and secondary hospitals to keep 40 percent of the total user fee and use it to improve the working of the hospital services

- The actual proportion of hospitalised paid patients was less than 10% in the five district hospitals.
- Diagnostic and bed charges constituted the highest proportions of the highest user fee.
- USER FEES PLAYED A MARGINAL ROLE IN STRENGTHENING NON SALARY INVESTMENTS

Generating revenue from the user fee and exempting poor and marginalized population are contradictory in situations where poverty is ill defined and exclusive. To deal with this contradiction the notion of exemption was adopted

How does user fee act as Barrier to Access Health Care Services?

SHIFTS IN USER FEE POLICY IN TERTIARY & SECONDARY HOSPITALS: 1995, 1998 & 2002

FEATURES	1995	1998	2002
PUBLIC SECTOR HOSPITALS COVERED	All Medical College & Hospitals, Other Teaching Institutes, State General, Sub Divisional & District Hospitals	Coverage Remained the Same	Coverage Remained the Same
GRADED USER FEES	YES	YES	YES
OPD CHARGES	Re. 1/-	Re. 1/-	Rs. 2/-

FEATURES	1995	1998	2002
BED, OPERATION, INVESTIGATION CHARGES	Revised and Increased each time	Revised and Increased each time	Revised and Increased each time
DIET CHARGES	No Charges	No Charges	Charges were Introduced
PAY BEDS	Not Available	Recommended to convert 30% of total beds into pay beds	Recommended to convert 30% of total beds into pay beds

EXEMPTION POLICY

FEATURES	1995	1998	2002
WAIVERED CATEGORIES	Patients from flys. With monthly income Rs. 1500 or below per month	Patients from flys. With monthly income Rs. 1500 or below per month	Patients from flys. With monthly income Rs. 2000 or below per month
	Mentally Challenged Patients Children with orthopedic problem	Mentally Challenged Patients Children with orthopedic problem	Mentally Challenged Patients Children with orthopedic problem Children below 1 year

SERVICES EXEMPTED	**Emergency patients admitted to ICU were provided free bed**	**Not Applicable**	**Not Applicable**
	Certain minor operations and commonly done investigations for OPD patients	**Number of exempted services were reduced**	**All the services were charged** **Obstetric Procedure exempted (2006)**
	Emergency cases in OPD, Treatment for TB, Leprosy, Malaria, STD, ANC under NHP are treated free	**Emergency cases in OPD, Treatment for TB, Leprosy, Malaria, STD, ANC under NHP are treated free**	**Emergency cases in OPD, Treatment for TB, Leprosy, Malaria, STD, ANC under NHP are treated free**

Free beds were treated as pay beds, diets were charged if poor patients could not produce authorised BPL certificate within the three days of hospitalisation.

In postgraduate (PG) medical college hospital, there were no free beds. Of the total beds, the Surgeon-Superintendent could allow a maximum exemption of 25 percent as free beds if the patients could produce authorised BPL certificate.

Poor patients cannot avail exemption by producing BPL certificate for the TMT, Colour Doppler and Echo Cardiography tests.

Exemption for Colour Doppler test and TMT test and Echo Cardiography was provided only by the state health department.

When the district hospital directly provided service like CT Scan
50 % exemption was applicable to all the patients with authorised BPL certificate.

HIGH TECHNOLOGY DIAGNOSTICS LIKE CT SCAN AND MRI WERE HANDED OVER TO THE PRIVATE SECTOR FOR DIRECT PROVISIONING.

- ✓ The state government fixed the price for the patients referred by the government health care institutions.
- ✓ No. of patients to be given exemption per month is fixed.
- ✓ The number of cases given exemption which actually get the test done per month is much less to the total number of CT scan and MRI cases done.
- ✓ Not all patients with BPL certificate were given exemption.
- ✓ Cost of Contrast is paid by the patient.
- ✓ In practice partial exemption was given.

OBSERVATIONS

- ✓ EXEMPTION POLICY ACQUIRED DIFFERENT MEANINGS UNDER SERVICE DELIVERY MECHANISM
- ✓ THE POOR COULD RARELY REACH THE HIGHEST LEVELS FOR EXEMPTION
- ✓ MADE SPECIALISED CARE OUT OF REACH FOR THE POOR PATIENTS
- ✓ PUBLIC SECTOR HOSPITALS ACTED PRIVATE PROVIDERS
- ✓ MORE THAN PROVIDING RESOURCES FOR THE HOSPITALS, USER FEES ARE BECOMING A MEANS OF PUSHING CERTAIN SERVICES AND SMOOTHENING THE PROCESS OF THEIR PRIVATISATION IN PROFITABLE AREAS OF WORK SUCH AS HI TECH INVESTIGATIONS