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# THE COST OF INSURANCE-BASED FUNDING

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Patients undergoing treatment at the Rajiv Gandhi Government General Hospital (RGGGH) in Chennai. | Photo Credit: JOTHI RAMALINGAM B.

The Tamil Nadu public health model is iconic. It has ensured equity in the delivery of health care, led to big improvements in maternal and infant mortality and universal immunisation coverage, and led to a low total fertility rate compared to the all-India average. In the public health sector, there are 19,866 doctors; 38,027 nursing staff; 60,181 supporting healthcare workers; a bed strength of 97,000 spread across 38 medical colleges; 18 district hospitals; 278 sub-taluk hospitals; 2,286 primary health centres (PHCs); 462 upgraded PHCs; and 8,713 health sub-centres. These cater to 5,76,174 outpatients per day and 2,15,35,000 patient bed-days a year.

There has been a change in funding for healthcare in the last decade. The funding mix varies from grants from the National Health Mission to the Chief Minister’s Comprehensive Health Insurance Scheme (CMCHIS). In this article, we look at the gains and the loss due to funding through insurance companies.

The State government pays a premium of 849 per family. In the last Budget, it had allotted 1,200 crore to extend insurance cover to 1.37 crore eligible families, with an annual income of up to 1.2 lakh. The Union government funds only a part of the responsibility at a 60:40 ratio for only 77 lakh families that fall under its criteria. The State government bears the insurance premium of the remaining 60 lakh families. The indirect funding through the insurance companies has ushered in massive changes in the functioning of the public health sector.

The central gain is the decentralisation of medical and healthcare administration. Powers have been substantially transferred to the heads of the department to purchase drugs. This has cut red tape. Decentralisation has empowered individual departments to prioritise their needs and hasten decisions in patient care in accordance with evidence-based medical advancement.

On the flip side, every department in the medical college has become an individual establishment. These departments compete with one another to maximise profit and minimise losses. As a result, secondary and tertiary healthcare systems are viewing patients and their ailments through the prism of indemnity. Negotiations with insurance companies have become cumbersome exercises for the already overworked patient care teams in public sector hospitals. Administrative delays by insurance companies have shifted the focus of hospitals from patient care, teaching and research to claiming money from companies.

The proportion of permanent staff with respect to rising patients in government hospitals has come down alarmingly. The appointment of 6,000 nursing staff and 9,800 allied health workers as contractual employees with meagre pay has driven a wedge through the workforce. Now, there are two categories: a permanent high-paid class versus a temporary low-salaried class. The alarming attrition rate among the contractual staff and the loss of well-trained staff in the new system leads to a compromise in the quality of service. Not extending the contract of nearly 350 dialysis technicians and 3,000 nursing staff has further fuelled a trust deficit among the young workforce.

Doctors in the primary health centres are functioning like managers rather than clinicians. Their focus seems to be on the implementation of Union government schemes using available finances. The newly created district health societies have brought in additional complications. These societies recruit doctors on a 11-month contract with a consolidated monthly emolument of 60,000, nurses for 15,000 and health workers for 8,500. These recruitments circumvent all the affirmative rules that have ensured social justice through the decades. It is deplorable that these young doctors under contractual appointments are not even eligible for reservation benefits in post-graduate medical education under the Tamil Nadu government in-service doctor's reservation scheme. The State has 10,725 MBBS seats per year in self-financing and government colleges. The irony of creating volume on the one hand and putting an end to employment opportunities through a 11-month contractual agreement on the other will open a Pandora's box.

Medicine is neither an absolute science nor a commodity but an art that needs passion and compassion. In the last 50 years we were able to achieve good indicators in health not because of administrators alone, but by ensuring that doctors came from different socio-economic strata and by empowering them with good pay and providing opportunities for post-graduation and super specialisation. They, in turn, infused the concept of modern medicine among the rural people of Tamil Nadu and made it a sustainable success. Mere profit-loss calculation and treatment of public health as a health industry will lead to an erosion of compassion among health professionals.

In Tamil Nadu, between 2012 and 2021, 7,783 crore was allotted in the CMCHIS to insurance companies. Of this, only 2,895 crore has been claimed by government hospitals. The remaining has flowed to private hospitals. This disproportionate 'diversion' of funds will further shrink funding to public hospitals.

Tamil Nadu has had a unique and robust policy framework. The current health policy and the methodology for its funding need an appraisal so that our monumental public healthcare system can be saved from systemic obliteration.

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