Who knew healthcare was so complex

The curious task of economics is to demonstrate to men how little they really know about what they imagine they can design.” —F.A. Hayek, *The Fatal Conceit: The Errors Of Socialism*.

NITI Aayog’s recommendation to improve access, reduce out-of-pocket expenditure, create infrastructure and augment capacity at district hospitals for non-communicable diseases (NCDs), is urgent and necessary. It deserves credit for recognizing that the public sector does not have the wherewithal to meet the NCD challenge and that the private sector is needed to address this gap. We highlight some remaining concerns.

The NITI Aayog’s solution is to incentivize the private sector via public private partnerships (PPPs), wherein the government provides land, infrastructure, capital for viability gap funding, and patients via referrals from public screening programmes. In return, the government fixes the price of basic services to ensure a reasonable rate of return. The delivery, quality and governance of the PPPs is monitored by the project steering committee, contracts management cell and project coordination committee, etc.

The first assumption here is that if sufficient incentive were provided to the private sector, through land and capital, then it would earn a reasonable return on equity and decide to enter. If so, then why not have a simpler policy: Earmark some land (within district hospital or outside) and provide subsidized capital to anyone who wants to enter these markets, and let market forces determine winners.

There are large fixed costs (and regulatory requirements), which are entry barriers, but provide reasonable returns to those who choose to enter. Here, patients will have choice, and competition will ensure that the most efficient players survive. Under the existing proposal, the selection, monitoring, evaluation, and governance of private players is done by the government.

Such a system suffers from two challenges: (1) It creates rent-seeking opportunities, which will adversely affect quality and quantity of care. It will attract private players with the greatest capacity to manipulate the system and not necessarily the most efficient ones. (2) In a competitive environment, performance of a firm changes over time depending on new and better management practices and technology. Firms with dynamic efficiency survive, while others stagnate. Under this proposal, however, the Herculean task of collecting continuous information on best practices, latest technology, quality of care improvements and cost reduction is left to government representatives. This is an impossible task.

The second challenge relates to tariff, which is non-negotiable and fixed by government. The biggest constraint in expanding health services is shortage of qualified human resources like onco-surgeon, clinical cardiologist and specialized nurses. These services are in high demand in big cities. In addition to higher salaries, there are large differences in quality of life between tier 1 and smaller cities. To induce migration from metros to smaller cities, private players will have to pay higher compensation. With fixed tariffs, this lowers profitability of the venture. For viability, there will be cost-cutting, potentially lowering the quality and quantity of care.

The third challenge relates to key performance indicators (KPIs), in particular, quality of care. Unfortunately, riskiness of patients is not considered while assessing quality of care. This will create two tiers of patients: (a) risky patients who are economically costlier than (b) non-risky patients who have fewer unscheduled visits and returns to operation theatre, etc. If payment is linked to KPIs, which are not adjusted for risk, then private players are disincentivized from treating risky patients while over-treating safer patients. There are also agency problems where

the doctor's interest is not aligned with that of the patient. Due to lower profits, doctors avoid treating riskier patients while over-treating safer patients by performing unnecessary procedures. This is a serious concern; for example, the latest National Family Health Survey shows that private hospitals carried out 41% caesarian sections as compared to 12% in government hospitals.

The fourth challenge relates to payments, which creates three types of patients: government-sponsored, self-paying, and patients insured under government schemes. Tariff for each patient is uniform and fixed but the economic cost varies. Government-sponsored patients are more expensive because 70% of their payment is released within 30 days while 30% is released within 45 days after "due diligence". There are several ways for government representatives, with no skin in the game, to hold up payments. For self-paying patients, funds are transferred within 15 days of receipt. Facilities, therefore, prefer self-paying patients and are reluctant to provide the same level of services to government-sponsored patients who are typically poorer. Private hospitals in Delhi have reserved beds for poor patients in lieu of subsidized land given by government. What is the evidence from this earlier version of PPP? We must check occupancy rates of reserved beds and the poor's access to these facilities. The NITI Aayog has made a promising start, but must address these challenges. It would be *fatal conceit* to believe in simple solutions to complex problems.

This is the third article in a four-part series on reforms in the healthcare sector.

Part 1: Restructuring the Medical Council of India to eliminate corruption

Part 2: What Uttar Pradesh tells us about health infrastructure

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