Health Economics

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Week – 12

Lecture 59- Healthcare Provisioning and Responsiveness

Welcome, friends, to our NPTEL MOOC module on Health Economics. We are in the final week, where we focus on healthcare provisioning and their responsiveness, which leads to understanding public health. So, this unit focuses on responsiveness, the health system, and so on. So, in the previous lecture, we discuss public health, its definition, its function, its core activities, and ethical issues. Here, we will be emphasizing health system responsiveness, and hence, we are addressing healthcare provisioning and health system responsiveness. The following will be discussed step by step on components of HSR and the impact of demand and supply.

Then what do you mean by health provisioning? We have to refer to the standard work of the WHO of 2016. It states that all services pertaining to illness, diagnosis and treatment, or the promotion, maintenance, and restoration of health are part of the category of healthcare provisioning. This includes both personal and non-personal health services. In particular, focusing on provision refers to how resources like cash, personnel, supplies, and medications are brought together to enable the delivery of medical interventions, as mentioned in the same work of WHO 2016.

Hence, healthcare provisioning refers to the planning, organization, and delivery of health services to meet the health needs of individuals and communities. This encompasses a broad range of activities such as the establishment of healthcare facilities, deployment of healthcare professionals, development of healthcare policies, and management of resources, which will ensure the effective and equitable delivery of healthcare services. One thing is important to note that collaboration amongst a range of stakeholders, including government organizations, healthcare providers, insurers, academic institutions, and the community, is indeed necessary for the effective provisioning of healthcare. The key component of healthcare provisioning hence also includes stakeholders such as healthcare professionals, policy, regulations, information systems, workforce development, and community engagement for health promotion. Then what do you mean by healthcare facilities? This includes clinics, health centers, hospitals, and specialized centers.

To specify a few, like in hospitals, we also need to take care of emergency care, surgeries, and specialized treatment. Clinics and health centers include PHC primary care services at the PHC level, preventive care, and basic diagnosis and treatment services. These are more accessible to communities and play an important role in promoting health and preventing diseases. Specialized centers focus on specific areas of healthcare, such as mental health clinics, rehabilitation centers, and specialized clinics for chronic diseases. Healthcare professionals who are part of healthcare provisioning include physicians, surgeons, nurses, administrative staff, and allied health professionals.

So, health information system includes electronic health records, master facility list, and health information exchange. Healthcare policies and regulations are important. This pertains to financing as well, which includes health insurance, public funding, reimbursement mechanisms, etcetera. Quality assurance is another aspect of this provisioning, and it is also part of healthcare policies and regulations. This includes the implementation of standards and protocols to ensure the quality and safety of healthcare services.

Another aspect is called the regulatory framework. This encompasses laws and regulations that govern the practice of healthcare professionals, the operation of healthcare facilities, and the overall healthcare system. So, as I already mentioned, community engagement is also another pertinent aspect of health provisioning. This includes PHC campaigns, public health campaigns, health campaigns to promote healthy behavior, prevent disease, educate the public on health-related issues, and community outreach such as programs that engage with communities to understand their healthcare needs and address health disparities. Workforce development, including training and education, like health-related education and health-related professionals and training will enable skills to maintain the standard of healthcare provisioning, then include workforce planning and management that includes strategic planning, which will ensure an adequate and appropriately skilled healthcare workforce.

So, healthcare technology that includes medical equipment has provisions for the acquisition and maintenance of medical devices and equipment used in diagnosis, treatment, and patient care. Telemedicine provides healthcare services remotely, including access to care using a cell phone or even tablet, mobile through the internet, examples like 1MG and PRACTO. So, there are a number of such examples across the globe. The goal of healthcare provisioning is to ensure that health services are accessible, affordable, and of better or higher quality and that they are responsive enough to the diverse needs of the people. However, in reality, these expectations are compromised in some cases.

Hence, we need to unfold the healthcare cases with reference to India at this moment. So, as per the latest micro large-scale information based on the survey from the household, which was conducted by the National Sample Survey in its 75th round, which was in 2017-

18, which emphasizes the treatment of the ailments based on short-run and long-run ailments with 15 days and 365 days cases. Government hospitals in case of 30 percent of ailments, and private hospitals in case of 23 percent of ailments. So, these are the facts derived from the NSS 75th round. Private doctors and clinics are actually accessed in case of 43 ailments.

Informal healthcare providers and charitable trusts, NGO-run hospitals in case of the remaining 44.1 percent. These are OPDs, outpatient departments, or doctor treatment. Inpatient hospitalization cases, excluding childbirth, are also recorded. Public hospitals accounted for 42 percent; private hospitals also accounted for more than that. Hence, the out-of-pocket expenditure is also higher.

In charitable trusts, NGO-run hospitals account for 2.7 percent. Population with health expenditure coverage like 14 percent of the rural population and 19 percent of the urban populations is covered per health expenditure is concerned. 13 percent of the rural and 9 percent of the urban population covered by government-sponsored health insurance, 1 percent of rural and 6 percent urban covered by health insurance arranged by government PSUs as employer and employer supported health protections schemes. 4 percent of the urban population is covered by health insurance arranged by households with insurance companies.

Average medical expenditure per hospitalization case as per the NSS 75th round, in rural India about rupees 16,676, and rupees 26,475 in urban India that is average medical expenditure per hospitalization. You can refer to the National Health Accounts 2019 figure as well, which is the latest, and the government public hospitals are accountable for the average medical expenditure, which is rupees 4452 on the aggregate, which is 4290 in rural and 4837 in urban areas. Private hospital and expenditure was about 31845 rupees, and rural and urban decompositions are mentioned. We are directly referring to the official data. The high proportion of out-of-pocket expenditure OP in private care is the consequence of the lack of public health provision. So, it is to be noted that this lack is actually resulting in a higher burden on the households.

Due to this, the private sector acts as the main provider of health services with a lack of proper regulation of prices and services. To pay for inpatient care, more than 64 percent of rural households and 40 percent of urban households with hospitalized cases borrow their money or sell assets and rely on donations from friends or family, as Joe's 2015 work highlighted. To improve the access, affordability, and accessibility of services and health-seeking behavior towards public provisioning or public care, the health system should be accountable and should be highly responsive and efficient enough. Hence, it directs to the understanding of HSR and health system responsiveness. What is this all about? It explains a system, a health system that has a certain level of responsibility to the non-health expectations of the people.

So, it is to be emphasized that the health system's responsiveness actually accounts for people's non-health expectations. So, it is not directly related to the treatment; it has to address the non-health expectations directly. According to the WHO 2000 report, the non-health expectations of the people have 8 domains such as dignity, autonomy, confidentiality, prompt action, quality of amenities, clarity of communication or information, choice of providers, and access to social support networks. So, you can note that these are not directly linked to the health requirements.

These are beyond health. Hence, it is mentioned non-health expectations. So, dignity refers to the experience of the patients or individuals of being treated respectfully, and their privacy is indeed respected. Autonomy has to be the freedom and experience of the patients involved in making decisions for their treatment. A large proportion of people were not always provided with various treatment options. So, treatment options should be provided to help them make their decisions.

Hence, patient acceptability is used to be a question in the Indian health system. So, autonomy really matters. Healthcare providers have not prioritized providing treatment options or asking for their acceptability. Note here that the training and orientation of the healthcare providers are required, which is most in this direction that will prioritize the patient to seek their treatment and that will also, to a large extent, minimize their out-of-pocket expenditure. Regarding confidentiality, another important aspect of the health system responsiveness includes factors related to secrecy, such as whether information shared by the patients or individuals with providers is kept secret or not.

So, that is creating confidence in healthcare access. This includes private space for the patients to be able to talk privately to the providers. Another is prompt attention, which refers to how quickly the issues are addressed, including waiting time, time to reach the hospital facility and mode of transport. You might have heard that developed countries have a dedicated line for the ambulance service and emergency transport services to have a quick connection to this access. So, a public policy discussion must focus on a dedicated line.

Even if our population is huge, it can be greatly managed. The chaos can be greatly managed. So, waiting time is important. We discussed patient travel as we all witnessed that going from a far-flung area to reaching the place is a really cumbersome process and indirectly incurs huge costs. Patients with no out-of-pocket expenditure for transport to reach the hospital are required. Hence, the patient will be highly satisfied.

Quality of amenities, how far the quality and functionality of the amenities are also important, such as cleanliness, even nearby the waiting area like toilets, availability of drinking water, and sitting capacity. Then, clarity of communication and information is provided by the providers to the patient. You might have heard that the patient is from a

rural area or from a different region with a different language. Since we have a huge number of languages, the patient may not be able to actually express correctly. Hence, the health system must be geared enough and must be trained enough to be capable of understanding the communication of the patient.

So, they should listen carefully and clearly, and they must understand especially to cater to the needs of the patient. The choice of the providers is already said to a large extent. We discussed autonomy, and it may overlap with that. Access to a social, in case of choice, investigates whether patients or individuals are able to see a healthcare provider of their own choice. So, this is what is to be emphasized. Another one is called the social support network, which is prominently related to inpatient care but is also valid for outpatient care.

This allows your family members of the relative that used to have huge confidence in the mind of the patient who is already hospitalized. So, as mentioned here in the WHO work of 2000, the recent literature finds that trust in the doctors and providers is also a very important factor that dominates responsiveness. So, you can also relate to the remote areas and the villages people rely on since the health system is not that good or not that trustworthy or may be lacking in many indicators. Hence, those far-flung areas, especially villages in remote areas, still depend on the quacks, the sharp h, and the traditional home-based based medicines. So, even if those are not clinically proven, people are still dependent on them.

So, coming to HSR once again improves access and acceptability, and to improve access and accessibility, the acquisition of knowledge, self-efficacy, attitudes, and health behavior are important, and hence hea, literacy really matters. Health literacy is important for the health provider as well as the patient, but most importantly, it is the health providers. Health literacy refers to the capacity to acquire, process, and understand healthcare information and services required to make suitable decisions related to wellness and patient care. Hence, to present it in a structured format of the HSR, we have supply side and demand side aspects in the agents, and the supply sides are important like political leaders, policymakers, managers, service providers, etcetera. This helps in efficient and proper function.

However, we have a demand side as well. However, the agents of the supply side will help in health system efficiency through their various inputs, such as public financial management, decentralization, accountability, policy and regulations, and health promotion. But it is quite unfortunate to see that these aspects as the inputs are usually geared off just before the election time and just to claim as a popular measure that is really unfortunate and might break the sanctity of the health system. Hence, to whom it should be blamed, the academician; it is the right of the academician and the policymakers to cross-check how far these machinery are actually diluting the system. So, since the political

leader is at the forefront of politics and is considered to be rich enough in all directions, education really matters.

Hence, we need to discuss public financing management, decentralization, accountability, public regulation, patient rights, empowerment, and health promotion. So this leads to major impacts such as better quality, high quality, health behavior, financial protections, and motivation of the health workers. On the demand front, the demand for health services is triggered mainly by three levels of the agents: community, family, and individuals. These will also have specific characteristics. It bears with socio-demographic characteristics, individual factors, and accessibility-related factors; it even has dimensions related to political characteristics and health security.

Each level has different medical and non-medical expectations depending on their vivid characterizations or characteristics. So, all those things really matter. Each level has different medical and non-medical expectations. So, in the outcome, we would have a better quality because it is cross-checked with the demander side. So, medical expectations and non-medical expectations are part of the health system response and are well addressed.

So, what we have discussed about demand and supply for HSR will guarantee health literacy. Organizational health literacy is also important; in organizations where we mentioned the supply side literacy aspect, community health literacy is also equally challenging and important, and very few papers will be found on these, especially in the Indian context; I will suggest you focus. We are actually working on it. My scholars are contributing hugely to this direction. So, I hope we have taken off all possible aspects of HSR. These are the readings that further substantiate your understanding.

So, that is all. Thank you for today. Expecting your presence. Thank you.