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Out-of-pocket health expenses and India's poor

Out-of-pocket (OOP) expenditure in health is a major component of the household expenditure of health service users, and a source of concern especially for developing countries like ours. In India the structural adjustment programmes of the 1990s led to the central and state governments limiting the funding for the social sector. User fees were introduced in the public healthcare sector in the 1990s. Despite progressive efforts like the Drug Price Control Order which was meant to ensure affordability of some commonly used drugs, liberalisation, including liberalisation of the pharmaceutical sector in 2002, has sent prices spiralling upwards. When 90% of the population has no health insurance coverage, rising prices have left a large number of people unable to access healthcare.

These policy changes, along with growing poverty nationwide, have stretched the spending capacities of poor Indians.

The author uses quantitative data from various national surveys to measure the extent to which household living standards have been affected, across income groups and states. It is found that the richer states have an increased OOP expenditure for healthcare, and the overall OOP expenditure for healthcare has increased over the past one decade. However, this increase is primarily due to higher expenses among the rich. This emphasises the fact that the poor must choose between medical care and other essentials such as food.

Ghosh S. Catastrophic payments and impoverishment due to out-of-pocket health spending. *Econ Pol Wkly*. 2011 Nov; 19(25):63-70.

Evidence-based policy and healthcare models in India

In this article the author, who has been part of a successful public private partnership (PPP) model in healthcare, discusses the importance of implementation research in developing a successful model of PPP in healthcare. In his experience, the key to success lies in innovations. This is evident in healthcare PPPs in India through community health insurance, mental healthcare at primary health centres (PHCs) through trained doctors, tele-electrocardiography services, mainstreaming traditional medicines and availability of staff. The state should also ensure its active participation in the process.

In many parts of India PHCs are not used either because they are too far away or because their service delivery is of poor quality. In this situation, it is easy to opt for a partnership between the state and the private sector in which the latter provides partial or full support to need-based primary healthcare services, or even to emergency obstetric care. Though the involvement of the private sector has gained importance among policy makers in India, very little research has been done to provide useful inputs at the policy level. The author points out that along with recording the success stories of PPPs in primary healthcare, it is equally important to look into the failures. Through implementation research it is essential to explore the mechanisms through which it works or does not work. The author establishes the importance of scientific evaluation and evidence of 'what works for whom and under what conditions', rather than just focusing on 'whether or not it works'. This will help formulate more innovative policies in this field.

Prashanth NS. Public-private partnerships and health policies. *Econ Pol Wkly*. 2011 Oct 15;46(42):13-5.

Should doctors recommend kidney donation?

Kidney transplants are required for persons suffering from end stage renal disease or acute renal failure. Due to increasing public awareness, the availability of kidneys from deceased or live donors has increased somewhat, but the demand for kidney transplants still far outstretches the supply, and many patients with renal disease die while waiting for a transplant. To meet this demand and for better acceptability of the recipient, doctors may sometimes encourage their patients to donate their kidneys while alive, as "living donors", to a stranger.

The risk of death associated with kidney donation is minimal (1 in 3,000). Other risks are post-operative complications and a reduction in renal function. Younger donors are able to recover faster, and the remaining kidney can more than compensate for the lost one.

Since the doctor-patient relationship is paternalistic, patients may feel that whatever the doctor advises them is good for them. In such a situation it is easy for doctors to misguide their patients or not provide full information about the pros and cons of living donation, thereby leading patients to opt to donate, without knowing the consequences.

Doctors should not recommend that their patients donate, for the simple reason that it may affect the post-operative life of the donor. The primary responsibility of doctors is to do no harm to their patients. In order to do good to one patient, they should not harm another. A healthy individual can express the autonomy to donate one kidney to a stranger, but this should not be the result of coercion by the doctor.

Glannon W. Is it unethical for doctors to encourage healthy adults to donate a kidney to a stranger? Yes. *BMJ*. 2011; 343 doi: 10.1136/bmj.d7179

Shielding healthcare workers from TB

Tuberculosis is a major public health problem in India, and this is also a problem faced by healthcare workers. Doctors and nurses get exposed to TB early in their clinical rotations, and

infection can progress into full blown TB during the course of their work. Nursing trainees are at the highest risk because they are at the bedsides of patients in overcrowded wards.

The incidence of TB among healthcare workers is much higher in developing countries than in developed countries. The prevalence of latent and active TB is much higher among healthcare workers than in the general population in the same area. Isoniazid preventive therapy (IPT) is recognised as an essential component of TB infection control. IPT programmes targeted at younger healthcare workers have worked better to prevent active TB.

This paper suggests that tuberculin skin testing of doctors and nurses be done on an annual basis. Those who have contracted the disease can be started on a dose of IPT after ruling out active TB disease. Preventive therapy should be monitored by experienced doctors and follow-up should be regularly done, with monitoring for adverse reactions to treatment. Further, maintaining hygiene, ventilating TB wards, and isolating TB patients would go a long way in controlling the spread of TB.

Raj R, Prasad H, Arya BK, Bhattacharya SD. Isoniazid preventive therapy programmes for healthcare workers in India: translating evidence into policy. *Natl Med J India*. 2011;24(4):101-7.

Somalia's struggle for basic healthcare

This report paints a grim picture of the realities faced by Somalis and the helplessness of international aid organisations working in conflict zones. The civil war raging in Somalia since 1991 has impoverished the country so much that even basic health services are a luxury. The drought in the region has pushed the population further into a state of despair. Migration, fuelled by the conflict, to neighbouring countries and to relatively stable areas within the same country, has resulted in overcrowded refugee camps which act as a hotbed for infectious diseases. Emergency assistance is always delayed. The health system is in a shambles and the lack of routine surveillance data makes the implementation of preventive and control measures all the more difficult. The efforts of international agencies are the only source of support in the area. There is an urgent need for people to overcome political differences and mistrust, and reach out to a nation and her people who are struggling for their survival and basic human rights.

Carbol JC. War, drought, malnutrition, measles- a report from Somalia. *N Engl J Med*. 2011 Nov 17;365(20):1856-8.

Public-private-partnerships in maternal healthcare

Healthcare policy in India encourages the public-private-partnership (PPP), with the state or no-profit agency tying up with a private/profit-making agency to disburse healthcare. The National Rural Health Mission specifically talks about the importance of such schemes. States have entered into different partnerships to provide tertiary and specialised care. The PPP may be set up as a contract, as a voucher scheme, or as networks and social franchises between partners. In the area of maternal health, states have launched a range of PPPs to tackle maternal mortality. However, many of these programmes have failed, and this article analyses the reasons for these failures: the barriers posed by user fees, the lack of specialised facilities and services such as blood banks, no provision for tackling emergencies in obstetrics, and an imbalance in the geographical distribution of services. Further, in the PPP model the balance of power between the public and the private partners is often tilted in favour of the latter, and the former becomes a marginal player. This adversely affects service delivery. Regular assessments have not been conducted for most PPPs, and there is a lack of transparency as to their effectiveness. The article stresses the urgent need for regular and proper evaluation of the nature and quality of PPPs before they are replicated by other states. It also calls attention to the need for these systems to be accountable to the general public.

Ravindran STK. Public-private partnerships in maternal health services. *Econ Pol Wkly*. 2011 Nov 26-Dec 2:43-52.

Change needed in medical examination formats

There is much discussion on the need for revamping the current medical education sector in India. The authors discuss concerns related to the use of "true/false" examination formats to assess the knowledge of students in medical examinations. They point out that when candidates choose the answer from two options, there is a high probability of guesswork being used. This considerably reduces the reliability of the test and the assessment of the real knowledge of the student. The authors suggest that even awarding negative marks for incorrect answers may not resolve the problem; punishments do not aid in modifying behaviour and may instead add to students' confusion about their performance. The true/ false question answer format rewards students for taking risks, which is unwarranted. The system also fails to understand the ability of the student to judge and resolve a particular clinical situation.

Alternative systems of assessment such as the Single Best Answer (SBA) and Extended Matching Items (EMI) systems are also discussed in the article. Both these systems provide a greater number of options to choose from, which reduces the probability of guesswork. They test students' cognitive abilities better. They also distinguish between high and low performers more accurately. While the true /false method has the advantage of "covering a lot of content with fewer questions" it is also less reliable and fails to capture the level of understanding of the student.

Madawa C, Margery D, Gominda P. Assessment of medical knowledge: the pros and cons of using true/false multiple choice questions. *Natl Med J India*. 2011;24(4):225-8.

Confidentiality, autonomy and beneficence

The case study and commentaries look into the issue of confidentiality and its breach in the patients' best interests. It describes the decision of a patient to undergo surgery in

another country against her physicians' strict instructions, in the hope that this will improve her quality of life. To complicate matters further, the efficacy of the procedure has not been fully proven. Now back in her home country, with her original physician, she chooses to disclose the information to the physical therapist of the medical team treating her. The therapist now faces the dilemma of whether or not to reveal this information to the treating physician. Revealing this information may breach the confidentiality of the patient. However, not revealing it may cause complications in the treatment and harm the patient. Laliberté M argues that the decision of the patient to withhold the information from her physician should be respected if there are no imminent and life-threatening complications that could arise out of the foreign procedure and if the patient is competent to take the decision to undergo that procedure. The author further points out that a breach of confidentiality would endanger the patient's trust in the medical team and could force the patient to discontinue her treatment altogether. Lantos JD and Gowda S suggest that the foreign treatment might warrant certain changes in the present treatment plan and in such a scenario, the patient's safety should be the primary concern. They also note that it is necessary to consider the relationship between the physician and the patient. Lantos and Gowda also suggest an alternative: the therapist can reveal the information to the physician who can make necessary alterations in the treatment regime and not inform the patient about the disclosure. The best route would be to encourage the patient to reveal the information to her treating doctor, or take her consent to reveal the information to the physician.

Laliberté M, Lantos JD, Gowda S. Confidentiality and its limits. Should one member of a medical team keep a patient' secret from the rest? *Hastings Cent Rep*. 2011 Nov-Dec;41(6): 12-3.

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We also now have a Twitter account: @IndJMedEthics; please follow us to get regular updates on journal content and news of interest in bioethics.