Towards a 21st Century Health Care System : Leadership Role for API

RD Lele

Hon. Consultant Physician and Director, Nuclear Medicine, Jaslok Hospital, Mumbai

186

INTRODUCTION

The World Health organization has defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

India has a long tradition of health-care. *"Ayurved"* (literally meaning science of life), clearly stated 2500 years back that – "the aim of medicine is three-fold :

1. Promotion of positive health
2. Prevention of disease
3. Treatment of disease when it arises

These 3 aims remain as important today as in the past. One new component as a part of treatment is rehabilitation.

Ayurveda emphasizes that health is not a commodity that can be purchased – it is an asset which has to be assiduously maintained with care and husbandry; by following rules of conduct regarding diet, exercise and behavior – "The body and the mind are both considered to be the abodes of disease, likewise, of well being. The cause of well-being is their harmonious and concordant interaction. The cause of disease, psychic or somatic, is either erroneous, absent or excessive interaction".

"Like the lord of a city in the affairs of his city, a charioteer in the management of his chariot, so should a wise man be ever vigilant in the care of his own body and mind", "Diseases occur in those who do not observe the rules of healthy living. Hence the healthy man should be diligent in the observance of the rules of healthy living- "*Swastha Vritta*" for the body and "*Sad Vritta*" (ethical conduct) for the mind".

Health Maintenance and disease prevention need a *partnership* between the individual and his family and the family doctor who is a teacher and guide. The current terms such as "consumer", "provider of health care" and "marketing of health care" are repugnant to the concept of this patient-doctor partnership based on trust (fiducial relationship). I suggest that the 21st Century Health Care System should be based on this trusting partnership.

While talking about "Health care" most people ignore the 1st and 2nd components and concentrate only on the third component. "Health care" has therefore become synonymous with "Illness care". The so-called Health care Industry also is concerned with illness care, pushing the importance of promotion of positive health and prevention of disease to a poorly neglected secondary position. The undesirable consequences of this approach have been realised world-wide.

UNHAPPY CURRENT STATE OF AFFAIRS

There is wide-spread and growing discontent with the prevailing health care system world-wide. The richest country in the world, USA, which spends 18% of its GDP on health–related expenses is not happy with the current state of affairs.

The Institute of Medicine (IOM) in USA has stated in 2001: "The American Health Care Delivery System is in need of fundamental change. The current care system cannot do the job. Trying harder will not work. Changing systems of care will".

"Between the health care we have and the care we could have lies not just a gap but a chasm" ("Crossing the Quality Chasm : A new Health System for the 21st Century 2001)[1]. The current system fails to fulfill six aims of quality health care : safety, effectiveness, efficiency, timeliness patient-centredness and equity. As regards safety the IOM document-" To Err is Human" in 1999 noted that almost 100,000 deaths occur yearly in that country alone due to medical errors, most of which are preventable. "Healthcare today harms too frequently, and routinely fails to deliver its potential benefits" – (IOM).

"Many patients, doctors, nurses and health care leaders are concerned that the care delivered is not, essentially, the care we should receive. The frustration levels of both patients and doctors have never been higher. Yet the problems remain".

According to IOM's assessment, the mainstream physician community in USA has failed to provide effective leadership-failed to step forward and accept responsibility and accountability in the critically important areas of clinical decision making.

For the past decade especially, most of the physician community in USA has been in steady retreat in the face of a daunting array of powerful challenges for influence : larger and even more powerful, for profit "managed care" insurance companies, megalithic hospital systems (with the capital to buy up and then break up profitable physician practices) and practice management firms focused on the share market" (F J Crosson, A J Weiland, R A, Berenson 2004)[2].

The acceptance of the professional responsibility to always place the interests of the patient above self interest in all forms, and to maintain the highest standards of competence, knowledge and integrity in the interest of patients' welfare, is the distinguishing feature of the medical profession and its special status in society

as a noble profession, and its special claim for leadership in health care.

The IOM exorts the medical profession to face six challenges :

1. Redesign evidence-based care processes to meet the needs of the chronically ill for coordinated, seamless care across settings and care given.
2. Use information technology to automate clinical information and support clinical decision making.
3. Manage the explosion of new clinical knowledge through processes and tools for life-long learning and on-going licensure and credentialing.
4. Coordinate care across condition, services and patients' life spans.
5. Promote and advance *team–based care* through appropriate professional incentives and cultural change strategies.
6. Incorporate accountability at all levels of performance and outcomes into clinicians' daily work and professional expectations.

IOM calls for a "high quality, safer and more integrated 21st century health care delivery system, one in which the clinicians and health care institutions collaborate and communicate with the population to ensure an appropriate exchange of information and coordination of care".

Group responsibility of the physician community is the key to accountability and is the most basic organizing principle for providing quality health care in the most cost-effective manner to *all* segments of the population- rich and poor.

The concept of group responsibility and accountability has resulted in the recent formation of the Council of Accountable Physician Practices (CAPP) under the auspices of the American Medical Group Association to demonstrate the potential of pre-paid group practice (as exemplified by Mayo Clinic and Kaiser Permanente) to lead the physician community in improving the quality and affordability of health care http://www.amga.org/CAPP.

I propose that a dynamic partnership between doctors and the population through Health Maintenance Organizations (HMOs) and pre-paid group practice supported by health insurance cover is the paradigm for 21st Century Health Care. The current fee-for-service is oriented towards acute and episodic care. Per capita pre-payment in HMO facilitates chronic disease management. I have proposed to the Health Insurance Companies that they should actively support creation of HMOs and provide insurance cover through HMOs. Indemnity Health Insurance in it present form is doomed to fail in India. Health insurance should form an integral component of HMO.

THE KAISER PERMANENTE MODEL OF HMO

In September 2004 I spent some time at the Oakland California Headquarters of Kaiser Permanente, a pioneer organization in pre-paid health care in USA, with 8 million members currently provided with comprehensive healthcare in its full spectrum – primary promotive and preventive care secondary and tertiary care, hospital, nursing home and home care, in the least costly, most appropriate setting, not distorted by what an insurance company will or will not pay for. The distinguishing features are:

1. Financing and delivery of health care through *per capita pre-payment*, so that the physician organization has a budget for the care it will provide and an incentive to use the resources wisely.
2. Maintenance of continuous healing relationship with the voluntarily enrolled population.
3. Physicians and multi-disciplinary specialist teams can design and execute best care processes.
4. Hospital facilities and complex equipment can be deployed on a regional basis where it can be used with greatest proficiency and economy.
5. Electronic patient record (EPR) which provides an accurate and comprehensive picture of each patient. EPR avoids unnecessary duplication of tests, facilitates collaboration and coordination of care among specialties, and allows monitoring of compliance with the practice guidelines.
6. Over-use and misuse of tests and procedures, so common currently, is strongly discouraged while early detection and prevention and early treatment and chronic disease management are strongly encouraged. There is great emphasis on patient education and information. Patients are encouraged to come in early and have their symptoms checked so that any potential illness can be treated sooner and at much less cost. Emphasis on prevention has reduced need for inpatient hospital care especially for diabetes. Hypertension, congestive heart failure and asthma.
7. The medical peer group, not an insurance company, determines the clinical policies, which technologies and procedures will be employed and covered under the pre-payment.
8. The medical peer group develop the drug formulary themselves. The drug selection is based on its therapeutic efficacy, safety and cost. Physicians have the freedom to over-ride the formulary to prescribe what they believe is medically necessary in a particular case. This approach is most effective in cost control. In the current fee-for service scenario of medical practice, new single source patent protected drugs are aggressively promoted by drug manufacturers with little head-to-head comparison with older, effective and often less expensive drugs. HMOs use evidence-based approach to promote drugs of choice.
9. There is continuous review of the quality and cost-effectiveness of the care that is delivered.

NEED FOR PARADIGM SHIFT IN INDIA

The introduction of pre-paid group practice under an HMO necessitates a paradigm shift from the current fee-for-service pattern of medical practice in India. In the new paradigm health insurance is an integral component of an HMO, and managed care. The paradigm shift encompasses :

1. Change of emphasis from disease management to health management.
2. Shift of focus from curative to promotive and preventive aspects of healthcare and create the infrastructure especially for health education of the general population.

Table 1: Recommended Periodic Health Examination And Patient Education

Pregnancy	**Adult life**
Weight, Hb, BP, urine examination for albumin & sugar	Training for parenthood and family planning.
Prenatal care.	Family dysfunction : marital & sexual problems.
Supplement of iron, folic acid, calcium.	Guidance on health-related behaviour
	Exercise, weight control, alcohol, tobacco smoking.
Newborn	Coping with stress : Relaxation techniques
Neonatal hypothyroidism screen (TSH)	Early detection of high BP, diabetes, hypercholesterolemia & hyperlipidaemia.
Neonatal jaundice (Rh, viral hepatitis, HIV)	Early detection of ischaemic heart disease in high-risk groups
Immunization.	
Childhood	**Middle age**
Height-weight charts to monitor growth.	Females : Prevention of osteoporosis.
Records of milestones :	Self-examination of breasts.
Detection of mental retardation.	Papanicolau smears.
Dental care : caries, orthodontic conditions.	Males : Rectal examination for prostate.
Check for refractive errors : squint	Stools for occult blood. Annual blood test PSA
Check for hearing defects.	Flexible sigmoidoscopy
Both sexes : 'Empty nest syndrome'.	
	Joint families : closing generation gap.
Adolescence	**Old age :** Coping with progressive incapacity of old age
Sex education : awareness about STD & HIV	
Avoidance of teenage pregnancy.	**Rehabilitation:** Medical rehabilitation
Health-related behaviour : alcohol, drugs, smoking.	Vocational rehabilitation
Prevention of vehicular accidents.	Social rehabilitation
Emotional support : broken families.	Psychological rehabilitation

3. Change in the mind-set of the medical profession: self-discipline and social conscience to support the concept of HMO and "managed care", especially for the poor segments of population in urban slums and rural areas.
4. Spread awareness among the general public including organized corporate sector as well as individuals, regarding the need to become members of HMOs to get managed care as well as insurance cover for catastrophic illness.
5. Constant peer-reviews in the medical profession to lay down standards of care & cost effectiveness of care.

The city of Mumbai is a good place to start implementing the concept of HMO and managed care. A family physician will be responsible for the health of 1000 families (5000 individuals). The recommended periodic health examinations to be carried out by him are listed in table I. I have ascertained the willingness of 2500 family physicians in Mumbai who are willing to be part of HMO and managed care as a minimal component.

The 13 million population of Mumbai can be divided into 3 economic strata-rich, middle class and poor. The pre-paid subscription for HMO will roughly be 5% of their income. Even the poor are spending a lot of money for their illness beyond their means – they will have to be persuaded to give a regular monthly or annual subscription which will assure them both preventive care as well as curative care for minor illness and health insurance cover for major illness.

The corporate sector in Mumbai is relatively easy to be covered by the HMO concept.

The unorganized sector in the middle class is also manageable with some effort under the HMO concept. A survey of 100,000 middle class families revealed that on an average each family spends Rs. 10,000 per year for medical expenses. If these families give the same Rs. 10,000 per year as subscription to the HMO, a corpus of Rs. 100 corers per year becomes available, through which (a) each member of each family gets a free annual medical check up and the data is put on a 3½" floppy disk, to be carried each time a doctor is visited (b) the healthy eligible members get a health insurance cover through the HMO itself (c) those who are not eligible for health insurance still get a cover of their health problems including periodic consultations with specialists if and when needed, necessary investigations, hospital admissions if required, and drugs, all at a 50% discounted price which makes the HMO membership worth while for them. Unlike indemnity health insurance (where there are lots of exclusions and disclaimers), *there are no exclusions in HMO coverage*. Today there are 200000 HIV positive persons in the city of Mumbai. They will need emotional support as well as protection against opportunistic infections including tuberculosis for the next 10-15 years. HMO will be able to do that through its 2500 FPs. Patients with chronic diseases like arthritis, chronic bronchitis and asthma, diabetes, high blood pressure, coronary artery disease will get managed care. The FP will have access to the relevant specialists on the same day. Home care and rehabilitation are also an important part of managed care.

The real challenge is how to provide managed care to the 3 million poor citizens of Mumbai who also forced to spend a lot of money for their medical care. They will pay 5% of their earnings as their subscription and Government Municipal Corporation and philanthropy have to subsidize for their managed care.

THE RURAL HEALTH MAINTENANCE ORGANIZATIONS

The Government of Maharashtra has negotiated a World Bank loan to improve the standard of Community Health Centers (serving populations of 100,000). NGOs and private sector agencies are encouraged to play an important role in this effort. At a cost of Rs. 2.75 corers a 30-bed hospital (including staff quarters) can be constructed and Rs. 75 lacs will give the essential equipment. I have suggested that Banks give loans of Rs. 3.5 corers at low interest rate (4%) to a group of 4-6 doctors (physicians, surgeon, obstetrician / gynecologist, anesthesiologist etc.) to settle in rural areas to establish such hospitals, with a tax holiday for ten years. Insurance companies should encourage this development since it will help them to expand their business especially through health maintenance organizations.

The Insurance Regulatory and Development Authority of India (IRDA) has made it mandatory for health insurance companies to have significant presence in rural areas. As part of fulfilling this obligation IRDA requires a detailed plan on how the insurance company will cover rural areas. I have proposed to IRDA that health insurance should be an integral component of a health maintenance organization.

The Gram Panchayat should get a group health insurance for the entire village and can raise local taxes (for which the Panchayat has power) to pay the group insurance premium. The main problem is referral of the insured villager to the nearest community hospital. The first hurdle is approach roads. Over 70% of Indian villages have no approach roads to the main roads. A Village woman in difficult labour cannot reach the nearest hospital for want of quick transportation; with the result that one woman dies during delivery every six minutes in this country. Construction of approach roads is included in the activities under the rural employment guarantee scheme and should be undertaken on a priority, to allow access to ambulances and mobile health vans to remote villages.

PUBLIC PRIVATE PARTNERSHIP

It is going to be the crucial strategy for introducing the concept of rural HMOs in India, considering the clear inability of the government on its own to increase the required financial inputs for rural health care, both preventive and curative. Private partners may adopt primary health centre and community health centers. Groups of doctors from cities should be encouraged to migrate to rural areas to run the PHCs and CHCs. This remedy to correct the gross mal-distribution of doctors is long over-due.

I urge all physicians in India to read C K Pralhad's book "Fortune at the bottom of the Pyramid" which will change their entire thinking about the urban and rural poor. Pralhad exhorts us to stop thinking of the poor as a burden on society requiring charity & subsidies to be permanently doled out by the state, and start recognizing them as resilient and creative entrepreneurs and value-conscious customers. By innovative approaches such as micro-financing and micro-health insurance we can provide them cost-effective healthcare – not as charity but as profitable professional endeavour. We need vision, innovative thinking and sustained effort to succeed in this objective.

API should take the lead in educating the general public and policy makers in Government, how voluntary contribution to a pre-paid HMO is the most cost-effective approach to receive comprehensive health care. In India today 80% of medical expenses are out-of-pocket of the citizens. Medical expenditure on illness is the second commonest cause of rural debts. Every year 20% of the population above the poverty line is pushed below the poverty line due to costs of hospitalization. All this can change.

The importance of HMO approach with emphasis on prevention for the entire Indian community will be appreciated by the fact that by the year 2025, half the world's population of diabetes Mellitus will be in India. Mumbai will have its own share. We Indians are at high risk for abdominal obesity, high Blood Pressure, type 2 Diabetes and Coronary Artery Disease (CAD). All of these illnesses have their origin in childhood hence prevention begins in childhood. Normal healthy children and siblings of patients with the above 4 conditions show abnormal metabolic changes (eg. high fasting insulin, low HDL high LP (a) even in childhood. Fortunately expression of their genes can be kept under control by regular exercise, diet containing 400 gm. of fruits and vegetables, avoidance of putting on weight (abdominal girth > 90 cm.), and avoidance of smoking or tobacco use. Prevention is far better and cheaper than cure. Strong physician leadership is the crucial factor in making the HMO concept a reality. What needs to be done is clear. Are we going to do it ?

REFERENCES

1. Institute of Medicine: Crossing the Quality Chasm. A New Health System for the 21st Century. Washington D C 2001 National Academy Press.
2. Towards a 21st century Health System : The contribution and promise of Prepaid Group Practice A. C. Enthover and L. A. Tollen (Eds) Jossey. Bass. John Wiley & Son 2004.
3. Pralhad CK. Fortune at the bottom of the pyramid Wharton School Publishing 2004.