

Healthcare in India: Changing the Financing Strategy

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Abstract

The way in which healthcare is financed is critical for equity in access to healthcare. At present the proportion of public resources committed to healthcare in India is one of the lowest in the world, with less than one-fifth of health expenditure being publicly financed. India has large-scale poverty and yet the main source of financing healthcare is out-of-pocket expenditure. This is a cause of the huge inequities we see in access to healthcare. The article argues for strengthening public investment and expenditure in the health sector and suggests possible options for doing this. It also calls for a reform of the existing healthcare system by restructuring it to create a universal access mechanism which also factors in the private health sector. The article concludes that it is important to over-emphasize the fact that health is a public or social good and so cannot be left to the vagaries of the market.

Keywords

India; Health equity; Health financing; Universal access

Introduction

Access to healthcare is critically dependent on how healthcare provision is financed.¹ Countries that have universal or near universal access to healthcare have health-financing mechanisms in which either a single autonomous public agency or a few coordinated agencies pool resources to finance healthcare. All OECD countries, excluding the USA, have such a financing mechanism. In these countries, 85 per cent of financing comes from public resources like taxes, social insurance or national insurance, which ensure healthcare reaches over 90 per cent of the population. The health financing system in USA has resulted in poor access to healthcare compared to other OECD countries such as Canada. Outside the OECD group a number of developing countries in Latin America, Asia and Africa, such as Costa Rica, Cuba, Argentina, Brazil, South Africa, Kenya, South Korea, Iraq, Iran, Thailand and Sri Lanka, have also evolved some form of single-payer mechanism

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to facilitate near universal access to healthcare. It is only in countries like India and a number of developing countries still reliant mostly on out-of-pocket payments where universal access to healthcare remains elusive. In such countries, those who have the capacity to buy healthcare from the market most often get healthcare without having to pay for it directly, whereas those who suffer a hand-to-mouth existence are forced to make direct payments, often with a heavy burden of debt, to access healthcare from the market.

India is the most privatized health economy in the world and this is despite the fact that three-quarters of the country's population is either living below the poverty line or at subsistence level. Given the political economy of India one might have expected the state to be the dominant player in both financing and providing healthcare as, for example, in Sri Lanka, out of a concern to establish equity in access to healthcare.

The Political Economy of Healthcare Financing

Historically, the Indian State has always been an insignificant player in the provision and/or financing of ambulatory healthcare. Private providers, both modern and traditional, as well as informal providers, have been the dominant players in the healthcare market. The establishment of modern medicine during the colonial period gradually moved traditional arrangements in the direction of commodification. Even the traditional and non-formal providers (often practitioners of quackery) now use modern medicine in their practice and operate within the market context. In the case of hospital care, the transition has been very different. Right from pre-colonial times, through the colonial period and the post-Independence period up to the mid-1970s, the State and its agencies were the main providers and/or financers of hospital care. There were also significant non-state players who set up large charitable hospitals. By the 1970s medical education had made a major transition: post-graduate studies, specialization and super-specialization became important characteristics of medical practice. On the one hand, specialists began setting up private nursing homes while, on the other hand, the corporate sector began to show an interest in entering the hospital sector. Major changes in medical technology, which hastened the process of commodification in healthcare, made for-profit hospitals a lucrative proposition. By the 1980s the State was already decelerating investments in the hospital sector and the privatization of this sector of healthcare began to blossom. The National Health Policy during the sixth 5-year plan (MoHFW 2003) acknowledged the need for the privatization of healthcare. By the turn of the millennium the for-profit hospital sector had not only become dominant, but had become the order of the day, even within state sector privatization, via user-charges, as well as through contracting out or leasing services.

Latest estimates based on national accounts statistics (Central Statistical Organisation (2004) indicate that private expenditures on healthcare in India are about Rs 1,650 billion, of which 99 per cent is out-of-pocket. Public expenditures on healthcare are about Rs 310 billion on top of this (table 1). Together this adds up to 6.5 per cent of GDP, with out-of-pocket expenses accounting for 83 per cent of the share in total health expenditures, or 5.5

Table 1

Financing healthcare in India 2004–2005

Source	Estimated users in millions ¹	Expenditure (Rs billion)
Public sector	290	310 (16) ³
Social insurance	80	30 (1.5)
Private sector	790	1650 (84) ²
Private insurance	12	12 (0.6) ⁴
Out of pocket	778	1638 (83.4)
Total	1080	1960 (100)

Note: These estimates include local government health spending. The figures in parentheses are percentages.

¹ Estimates derived by author based on NSSO (1998).

² Estimates derived by author based on Central Statistical Organisation (2004).

³ Compiled from Ministry of Finance (2004), Reserve Bank of India (2005), Labour Bureau (2002) and MoHFW (2002).

⁴ Private health insurance data estimates obtained through personal communication with insurance companies.

per cent of GDP. It has further been reported that even this small public expenditure is skewed towards the richer groups, particularly those living in urban areas (NCAER 2002).

This political economy of expenditure differentials also reveals that the largest source of financing healthcare in India is out-of-pocket or self-financing expenditure. Out-of-pocket spending on healthcare as a mode of financing is both regressive and iniquitous, especially for poorer households, i.e. the bottom three quintiles that are either below poverty line or at the threshold of subsistence. When illness strikes, such households just collapse. As the National Sample Survey (1995/6) shows, 'the estimated loss of household income per hospitalization episode in rural areas was 13.5 per cent of mean per capita expenditure for the poorest quintile' (NCAER 2002: 36). Furthermore, while this burden is being largely self-financed by households, a very large proportion of this does not come from current incomes. For hospitalizations especially, it comes from debt and the sale of assets.

Data from the 52nd Round National Sample Survey of 1995/6 (table 2) reveal that over 40 per cent of households borrow or sell assets to finance hospitalization expenditure, and there are very clear class gradients to this. Nearly half the bottom two quintiles get into debt and/or sell assets, in contrast to one-third of the top quintile. In fact, in the top quintile, this difference is reinforced by employer reimbursements and insurance. When we combine these data with evidence on the proportion not seeking care when ill (in case of acute ailments) in the bottom three quintiles by contrast with the top quintile – a difference of 2.5 times, with the reason for not seeking such care being mostly the cost factor – it becomes amply evident that out-of-pocket financing has drastic limits and is itself the prime cause of most ill health, especially amongst

Table 2

Key data for out-of-pocket expenditures, source of finance and for not seeking care across expenditure quintiles and social groups, NSS 52nd Round, 1995/6

	I Poorest	II	III	IV	V Richest	SC/ST	Other	All
<i>Outpatient</i>								
Rural								
Rs per episode	77	94	124	130	174	92	138	128
Urban								
Rs per episode	95	141	139	164	225	122	166	160
<i>In-patient</i>								
Rural								
Rs per hospital	1020	1197	1495	1931	4595	2789	3133	3102
Urban								
Rs per hospital	835	1499	1964	2765	7470	2046	4303	3921
Debt and sale of assets (per cent)	47	45	42	42	32			43
Did not seek care (per cent)	24	21	18	18	9			17
Cost as factor in not seeking care (per cent)	33	23	21	22	15			24

Source: Estimates derived by author based on NSSO (1998).

the large majority for whom this mode of financing health threatens their very chances of survival.

In sharp contrast, in those countries where near universal access to health-care is available with relative equity, the main financing mechanism is usually a single-payer system such as tax revenues, social or national insurance or some such combination, administered by an autonomous health authority that is mandated by law and provided through a public-private mix organized under a regulated system. Canada, Sweden, the UK, Germany, Costa Rica, South Korea, Australia and Japan are a few examples of this. Experience from these countries suggests that the key factor in establishing equity in access to healthcare and good health outcomes is the proportion of public finance in total health expenditure. In most of these countries public expenditure averages 80 per cent of total health expenditures (OECD 2003). By contrast, India, where public finance accounts for only 17 per cent of total healthcare expenditure, has a poor equity record in access to healthcare and health outcomes by comparison even with China, Malaysia, South Korea and Sri Lanka, where public finance accounts for between 30 per cent and 60 per cent of total healthcare expenditure (WHO 2004).

Thus, if India is to improve healthcare outcomes and equity in access, increasing the role of public health expenditure will be critical. Apart from this, the healthcare system will need to be organized and regulated within a framework geared to universal access. As India has its own peculiarities, any

Table 3

Health expenditure trends in India

Year	Public health expenditure (Rs billions) per cent of GDP		Private health expenditure (Rs billions) per cent of GDP		Per cent private to total health expenditure
1975/6	6.78	0.90	24.66	3.26	78.43
1980/1	12.86	0.99	52.84	4.06	80.43
1985/6	29.66	1.19	90.54	3.61	75.32
1991/2	56.40	0.96	160.65	2.73	74.01
1995/6	96.01	0.89	329.23	3.07	77.42
1999/2000	172.16	0.96	835.17	4.76	82.91
2000/1	186.13	0.98	981.68	5.18	84.06
2001/2	194.54	0.94	1100.00	5.32	84.90
2002/3	197.32	0.88	1250.00	5.60	86.36
2003/4 RE	235.06	0.84	1400.00*	5.00	85.62
2004/5 BE	249.28	0.83	1650.00*	5.50	86.84

* Estimates by author for private expenditures; RE = revised estimate, BE = budget estimates. Sources: (public) Ministry of Finance (various years). Finance Accounts of Central and State Governments, Ministry of Finance, New Delhi, Government of India; Reserve Bank of India (various years). Finances of State Governments, Mumbai, Government of India; (private) Central Statistical Organisation, Government of India, Private Final Consumption Expenditures, National Accounts Statistics, 2003.

system will have to be designed with this in mind. We cannot transplant, say, the Canadian or Costa Rican system into India intact, but we can learn from others' experience and adapt useful elements from systems in operation elsewhere.

Towards a New Financing Strategy

As already mentioned, India's health-financing mechanism is largely based on out-of-pocket expenditure, with the role of public finance actually in decline. Table 1 offered a profile of the current financing mechanism and expenditure in India and table 3 indicates trends in health expenditures over the last three decades. It is quite evident from these data that the public finance of healthcare is weakening and that private expenditures are becoming even larger. But this can be changed, using mechanisms listed below.

1. Within the existing public finance of healthcare, macro policy changes in the way funds are allocated could bring about a substantial improvement in equity by reducing the inequalities between rural and urban areas. Together, central and state governments currently spend Rs 300 per capita at the national level, yet this is inequitably allocated between urban and rural areas. The rural healthcare system gets only Rs 130 per capita and urban areas get Rs 600 per capita, a 450 per cent difference.² If allocations

were made simply on a per capita basis (as is done in Canada, for instance), then rural and urban areas would both get Rs 300 per capita. This would be a major gain for rural healthcare of over twice more money, which could help fill the gaps, in both human and material terms, in rural healthcare systems. The urban areas have municipal resources in addition, though they have to generate more resources to maintain their existing healthcare systems that, at least in terms of numbers (such as hospital bed : population and doctor : population ratios) have been adequately provided for. Such global budgeting could also mean autonomy over how resources are used at the local level. Doing away with the current highly centralized system of planning and programming in the public health sector would result in greater faith being placed in local capacities.

2. The public exchequer even today contributes substantially to medical education, to the extent that nearly 80 per cent of medical graduates are from public medical schools. This major resource is not fully being utilized. Since medical education is virtually free in public medical schools, the state should demand compulsory public service for at least three years from graduates from them as a return for the social investment³ (today only about 15 per cent of such medical graduates are actually absorbed into the public health system). Furthermore, a spell of public service should also be made mandatory for those wishing to undertake post-graduate studies, which currently attract as many as 55 per cent of public medical school graduates.
3. Governments could raise additional resources by imposing health cesses (levies) and taxes on health-degrading products, if they cannot be banned, such as cigarettes, *beedis* (small Indian cigarettes), alcohol, *paan masalas* (betel nut mixture) and *guthka* (tobacco), personal vehicles and so on. For instance tobacco, which kills 670,000 people in India each year, is a Rs 350 billion⁴ industry. A 2 per cent health cess on tobacco could generate Rs 7 billion annually for the public health budget. Similarly alcohol, which presently generates Rs 250 billion in sales turnover per year, could also bring in substantial resources if a 2 per cent health cess was levied. The same logic could also be applied to personal transportation vehicles, both at point of purchase as well as each year, through a health cess on road tax and insurance to be paid by owners. Land revenues and property taxes could also attract a health cess (i.e. a tax earmarked for public health, just as municipal taxes already have an education cess component).
4. Social insurance could be strengthened by making a contributory system similar to the Employee State Insurance Scheme (ESIS) compulsory across the entire organized labour market sector and integrating ESIS, the central government health scheme and other such social insurance schemes with the general public health system. In addition, social insurance will need gradually to be extended to other sectors of employment, using models drawn from experiments elsewhere in collective financing (as with the sugarcane farmers of south Maharashtra, for instance, who pay Re 1 per tonne of cane as a health cess, for their entire families to be assured of healthcare through the sugar cooperative). There are many non-governmental organization experiments in using micro-credit as a tool for health financing for members and their families. Large collectives, whether

they are self-help groups facilitated by non-governmental organizations or groups of self-employed people, such as the headload workers in Kerala, could buy insurance cover collectively, so as to provide health protection for their memberships. At least 60 per cent of the workforce in India has the potential to contribute to such a social insurance programme.

5. Other options to raise additional resources could be various forms of innovative direct taxes like a health tax similar to the profession tax (a tax on employment, so that those who are earners contribute a fixed amount, depending on their level of earning, each month, which funds the employment guarantee) deducted at source of income for the employed and in trading transactions for the self-employed. Using the Tobin tax route⁵ is a highly progressive form of taxation that, in an increasingly finance-and-service-sector-based economy, can generate huge resources without bearing too heavily on the individual, since it is a very small deduction at the point of transaction. What this basically means is that for every financial transaction, whether by cheque, credit card, cash, on the stock market, through foreign exchange, securities and so on, estimated to be Rs 1,000 billion daily, a very small proportion is deducted as tax and transferred to a fund earmarked for the social sector. For example if 0.1 per cent is the transaction tax, then for every Rs 100,000 the transaction tax would be a mere Rs 100 and this would generate Rs 365 billion per annum. This would not hurt anyone if it were made clear that it would be used for social sectors such as health, education, public housing, social welfare and so on.

The above are just a few examples of what can be done within the existing system, by making small innovations. But this does not mean that radical or structural changes should not also be considered. Ultimately, if we wish to ensure universal access with equity, we need to think in terms of restructuring and reorganizing the healthcare system, using a rights-based approach. This would require a multi-pronged strategy: building awareness and consensus in civil society; advocating rights to healthcare at the political level; demanding legislative and constitutional changes and, finally, reorganizing the entire healthcare system, especially the private health sector.

In short, we have to stem the growing out-of-pocket financing of the healthcare system and replace this with a combination of public finance and various collective financing options such as social insurance and other forms of collective fund-raising. The healthcare system needs to be organized into a regulated system that is ethical and accountable, that is governed by a statutory mandate and that pools together the various collective resources and manages autonomously the workings of the system in the interests of providing comprehensive healthcare to all with equity.

Conclusion

At present, one sees a greater political will to address public health needs via the National Rural Health Mission (NRHM), a flagship programme of the United Progressive Alliance ruling government which, in its manifesto declared

that the public healthcare should receive up to 3 per cent of the GDP to realize the goal of health for all. This affords a good opportunity to innovate and experiment with a restructured healthcare system, but such restructuring will be possible only if certain conditions are met:

- The healthcare system, both public and private, is organized under a common umbrella/framework.
- The financing mechanism of healthcare is pooled and coordinated by some single-payer system.
- Access to healthcare is organized under a common system which everyone is able to access without any barriers.
- The providers of healthcare services have reasonable autonomy in managing the provision of services.
- The decision-making and planning of health services is decentralized within a local governance framework.
- The healthcare system is subject to continuous public/community monitoring and social audit, under a regulatory mechanism geared to ensuring the accountability of all the stakeholders involved.

The NRHM framework (Ministry of Health and Family Welfare [MoHFW] 2006) tries, one way or another, to address the above issues but has failed to come up with a strategy for accomplishing such an architectural correction. The framework only facilitates a smoother flow of resources to the lower levels, calling for the involvement of local governance structures (such as *panchayat raj* institutions) in planning and decision-making. The modalities of this interface have not been worked out, however, with the result that local government involvement remains peripheral. A more thorough restructuring would require the following features. All resources, financial and human, must be transferred to the district level governments that will need to work out detailed district plans based on local needs and aspirations. An appropriate regulatory and accreditation mechanism must be put in place to facilitate the inclusion of the private health sector. Private health services, both ambulatory and hospital, must be contracted in on appropriate terms. Detailed bottom-up planning must be undertaken with regard to budgeting and the allocation of resources appropriately to different institutions and providers. Finally, all stakeholders must be trained to understand and become part of this restructuring process.

The implementation of the above process would be critically dependent on the state and central government agreeing to changing the financing mechanism and giving complete autonomy to district *panchayat* and health institutions. With the financing mechanism in place, both *panchayat* and the health bureaucracy district authorities would require appropriate capacity building to manage the restructuring of the healthcare system. Private health providers and their associations will have to be brought on board at an early stage through discussions that explain to them the benefits of joining such a system. Those serving in public health institutions will have to be trained and appropriately informed to manage and run such a system. Above all, local governance bodies and civil society groups will have to be oriented and become skilled in planning, monitoring and auditing the functioning of the system.

Since it will be difficult to undertake such restructuring across the board immediately, individual states could begin this process in a few districts, with technical assistance from experts associated with the national and state health systems resource centres currently being created under NRHM.

To conclude: it is important to re-emphasize that healthcare is a public good and not to be left to the vagaries of the market. Instead, it should be organized and regulated, using both public and private resources, for social benefit. Furthermore, the delivery of healthcare should be decentralized at an appropriate community level rather than (as at present) planned at the central or state level. The role of the centre and the state should be to formulate strategies, mobilize and disburse resources, and monitor outcomes. Such is the global experience where healthcare is universally accessible with equity. Why should it be different in India?

Notes

1. This is a revised version of a paper presented at a National Symposium of the Council for Social Development, New Delhi, October 2005.
2. These estimates are calculated by the author based on an assessment that the rural healthcare system effectively gets one-third of budgetary resources.
3. To train one MBBS doctor governments spend between Rs. 1.5 and 2 million and thus have every right to expect a minimal amount of public service in return.
4. The exchange rate of the Indian Rupee is US\$1 = Rs 45.
5. The Tobin tax is a currency transaction tax, first proposed by economist James Tobin in 1972 to help weak economies both by limiting currency speculation and by raising substantial sums for development.

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