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Contents

Reforming Health Policy and Financing under Globalisation

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Abstract

How healthcare is financed is critical for equity and universal access to healthcare. Countries having universal access have health financing mechanisms that are single-payer systems in which either a single autonomous public agency or a few coordinated agencies pool resources to finance healthcare. All OECD countries, except USA, have such a financing mechanism. In these countries, 85% of financing comes from public resources like taxes, social insurance and over 90% of the population is covered. Canada, Sweden, UK, Australia are a few examples. Experiences from these countries indicate that the key factor in establishing equity in access to healthcare and health outcomes is the very high proportion of public finance in total health expenditures.

Historically India began with a clear trajectory towards universal access as early as 1946 with the Bhore Committee plan but lack of political will prevented such development. In 1982, again post the first health policy a more serious engagement on this happened and public healthcare received a boost through the minimum needs program and in 1987 public health expenditure peaked to 1.5% of the GDP but with structural adjustment policies from early nineties this small movement forward got derailed and has since not recovered very significantly. Presently in India public resources committed to healthcare is one of the lowest in the world, with less than one-fifth of health expenditure being financed publicly. India has large scale poverty and yet the main financing source for health care is out-of-pocket expenditure. This is a cause of not only huge inequities we see in access to healthcare but also of large

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scale pauperisation. If India has to improve healthcare outcomes and equity then increasing public health expenditures will be critical. Apart from this the healthcare system will need to be organised and regulated, similar to countries like Canada or closer home like Thailand.

This paper focuses on health policy making and health financing strategies historically and shows how globalisation processes, specifically structural adjustment programs under World Bank oversight structurally altered health sector development in India taking it on a path of growing inequity. It concludes with reemphasising that healthcare is a public good and cannot be left to the vagaries of the market. To realise its social or public value it has to be organized and regulated using both public and private resources for social benefit. Such is the global experience where healthcare is universally accessible with equity. Why should it be different in India?

I. Introduction

Access to healthcare is critically dependent on how healthcare provision is financed. Countries that have universal or near universal access to healthcare have health financing mechanisms which are single-payer systems 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, excluding USA, 85% of financing comes from public resources like taxes, social insurance or national insurance which insure healthcare to over 90% of the population – even in the USA public finance (Medicare and Medicaid) constitutes 44% of total health expenditure but one-third of the population in the US is either uninsured or under insured. In fact the USA and Canada stand out in sharp contrast even though they are neighbours and strong capitalist economies. Canada gives healthcare access to its entire population free of cost at 40% of what the USA spends, and has health outcomes much better than the USA.

Outside the OECD group a number of developing countries in Latin America, Asia and Africa like Costa Rica, Cuba, Argentina, Brazil, South

Africa, Ghana, South Korea, Iraq, Iran, Thailand, Sri Lanka etc. too have evolved some form of single-payer mechanisms to facilitate near universal access to healthcare. It is only in countries like India and a number of developing countries, which still rely mostly on out-of-pocket payments, where universal access to healthcare is 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, and 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 privatised health economy in the world and this despite the fact that three-fourths of the country's population is either below the poverty line or at the subsistence level. Given the political economy of India one would have expected the State to be the dominant player in both financing and providing healthcare for considerations of establishing equity in access to healthcare. But this has not happened.

II. Political economy of health financing

Historically, the Indian State has always been an insignificant player in provision and/or financing of ambulatory healthcare. Private providers, both modern and traditional, as well as informal providers, have been dominant players in the healthcare market. While pre-colonial healthcare was still largely within the jajmani[1] realm of transactions, the establishment of modern medicine during the colonial period gradually moved it in the direction of commodification. Today the healthcare system is dominated by modern medicine and healthcare available largely as a commodity. Even the traditional and non-formal providers use modern medicine in their practice and operate within the market context.

1. The jajmani system was a set of economic interrelations across caste groups in the local community which had social sanction and linked to it mandatory social obligations. While at one level it facilitated economic organisation of the local community and assured livelihoods within both productive and service sectors, at another level it also restricted occupational mobility because occupational assignment under such a system was caste based, especially for service occupational categories. Hence the jajmani system also kept intact the economic basis of the caste system. Today it is largely destroyed but may be found in pockets in most states, but especially the Hindi heartland.

In case of hospital care the transition has been very different. Right from pre-colonial times, through the colonial period and the post-Independence period upto mid-seventies, the State and its agencies were the main providers of hospital care. There were also significant non-state players who set up large charitable hospitals. By 1970's medical education made a major transition; post-graduation, specialisation and super-specialisation became sought after and the character of medical practice changed. Specialists on one hand began setting up private nursing homes and the corporate sector on the other hand began to show interests in entering the hospital sector. Also major changes in medical technology, which hastened the process of commodification of healthcare, and the entry of private insurance in the health sector made for-profit hospitals a lucrative proposition.

By late 1980's the State was already decelerating investments in the hospital sector and this was a clarion call for the private sector to increase its presence. At the turn of the nineties structural adjustment reforms, the harbinger of globalisation, liberalisation and privatisation, impacted the health sector drastically. These macro-economic reforms rapidly transformed the gains of the public health system made under the minimum needs programme of the 6th and 7th Five Year Plans into a private sector led growth that gradually destroyed the public health system. On the one hand the government under financed the public health system (with public health expenditure falling from 1.5% of GDP in 1987 to 0.7% in 1994[2]) and stopped making new investments and on the other hand the private health insurance and corporate investments in the health sector, including the expansion of the medical tourism market, and the massive growth of private medical education, provided the vital support for private healthcare to bloom. By the turn of the millennium the for-profit hospital sector had not only become dominant but also within the state sector privatisation via user-charges, as well as through contracting out or leasing had become the order of the day. See the case of Mumbai in the box.

It is apparent from the above discussion that the largest source of financing healthcare in India is out-of-pocket or self-financing. Out-of-pocket

[2] See Leena Gangolli, Ravi Duggal, Abhay Shukla eds. (2005) Review of Healthcare in India, CEHAT, Mumbai.

spending on healthcare as a mode of financing is both regressive and iniquitous. Latest estimates based on National Accounts Statistics indicate that private expenditures on healthcare in India are now over Rs.3500 billion and 95% of this is out-of-pocket. Public expenditures on healthcare are about Rs.1000 billion additionally. Together this adds up to over 4.5% of GDP with out-of-pocket expenses accounting for 74% of the share in total health expenditures or 3.3% of GDP. This is a substantial burden, especially for the poorer households, the bottom three quintiles, which are either below poverty line or at the threshold of subsistence, and when illness strikes, such households just collapse. In fact, for the poorer quintiles the ratio of their income financing health expenditures is 2 to 4 times more than the average mentioned above. Further, while this burden is largely self-financed by households a very large proportion of this does not come from current incomes. A very large proportion, especially for hospitalisations comes from debt and sale of assets as indicated by various rounds of NSSO health surveys (NSSO 2006).

Data from the 52nd Round NSS of 1995-96 (Table 1) reveals that over 40% households borrow or sell assets to finance hospitalisation expenditures, 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; infact in the top quintile this difference is supported by employer reimbursements and insurance. When we combine this data with the ratio of 'not seeking care when ill' in case of acute ailments by the bottom three quintiles in contrast to the top quintile – a difference of 2.5 times, and the reason for not seeking such care being mostly the cost factor, it becomes amply evident that out of pocket spending has drastic limits and in itself is the prime cause of most ill health, especially amongst the large majority for whom such a mode of financing strains their basic survival.

In sharp contrast in countries where near universal access to healthcare is available with relative equity the major mechanism of financing is usually a single-payer system like tax revenues, social or national insurance or some such combination administered by an autonomous health authority which is mandated by law and provided through a public-private mix organised under a regulated system. Canada, Sweden, United Kingdom,

The Collapse of Mumbai's Public Health Systems

Mumbai historically developed a very robust public health system. Being the industrial and financial capital, even as early as late 19th century seths (merchant capitalists) gave huge donations to set up dispensaries and hospitals in Mumbai. Most of the older public hospitals received such benefits and developed into centres of excellence under public patronage – JJ Hospital, KEM Hospital, Nair Hospital and Lokmanya Tilak Hospital, all teaching hospitals. Post Independence the infrastructure expanded rapidly, both hospitals and primary care facilities and an overwhelming majority of Mumbaikars used such public facilities for their healthcare, especially for hospital and specialty care. To support such care the BMC (municipal corporation) spent 25 to 30% of its budget on public healthcare, including 3 teaching hospitals. This was true until the late eighties. Post (nineties) SAP reforms the financing of Mumbai's public health facilities saw a declining trend and at the turn of the new millennium in 2000 (the year in which Health For All should have been achieved) the health budget was down to less than 20% and right through the nineties no new facilities were setup. At the same time private healthcare was rapidly expanding and supported by health insurance was taking over hospital care from the public institutions, including its doctors and nurses. By 2006 health accounted for just 17% of the BMC budget and today it is at a low of 13%. This underfinancing has resulted in poor maintenance, inadequate supplies, frustration amongst staff and consequently decline of credibility in the public conscious. What added to this agony was that the economic reforms of the nineties brought in health insurance which through employer assistance led the middle class to opt out of free public healthcare and migrate to insurance supported private care for hospitalisations. With the middle class voice and aggression gone from the public hospitals the latter became institutions for the poor. It is no coincidence that the out migration of the middle classes was followed by the underfinancing of public hospitals in Mumbai. And then just before the new millennium user fees in public hospitals were systematically introduced for each service and this alienated even the poor from the public health system leading to the complete collapse of Mumbai's public health system.

Germany, Costa Rica, South Korea, Australia, Japan are a few examples. Experiences from these countries indicate that the key factor in establishing equity in access to healthcare and health outcomes is the proportion of public finance in total health expenditures. Most of these countries have public expenditures averaging 80% of total health expenditures[3]. The greater the proportion of public finances the better the access and health outcomes. Thus India, where public finance accounts for only 20% of total health expenditures, has poor equity in access to healthcare and health outcomes in comparison to China, Malaysia, South Korea, Sri Lanka, Thailand (and more recently even Bangladesh and Nepal) where public finance accounts for between 30% and 60% of total health expenditures[4].

Table 1: Key Data pertaining to out-of-pocket expenditures, source of finance and for not seeking care across expenditure quintiles and social groups, NSS 52nd Round, 1995-96

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

Source: Compiled from NSS 52nd Round data files, NSSO, New Delhi, GOI, 1998

[3] http://www.oecd.org/document/html accessed 2nd August 2005

[4] WHO (2004) World Health Report -2004, Geneva, WHO

In India public health expenditures had peaked around mid nineteen-eighties and thereafter there was a declining trend, especially post-structural adjustment period. The decade of eighties was a critical period in India's health development because during this period not only did the public health infrastructure, especially rural, expand substantially but also major improvements in health outcomes were recorded. After that public investment in health declined sharply and public expenditures showed a declining trend both as a proportion to GDP as well as in total government spending. This has also impacted health outcomes, which are showing a slower improvement if not stagnation. At the same time private health sector expansion got accelerated and utilisation data from the two NSS Rounds 42nd (Pre-1991) and 52nd (Post-1991) Round, a decade apart, provides ample evidence of this change (Table 2 and 3). Further the 60th Round in 2004, the last such survey, also shows the continuing trend of decline in public facility utilisation, especially for hospital care (Table 2).

Further evidence from states which underwent health sector reforms under the World Bank supported health sector development programme (HSDP, Table 4) clearly reveals huge declines in state public health budgets which were around 10% of the state budgets in 1987 (prior to WB interventions) but now since 1998 are halved at below 5%. This reduced budgetary support to public health has led to the destruction of the public health system, a loss of its credibility and ultimately their inability to achieve the desired health outcomes.

Thus, if India has to improve health outcomes and equity in access then increasing public health expenditures will be critical. It will have to reverse the post-1991 declining trends in public health spending and move towards the UPA government's target of 3% of GDP public health expenditure. Apart from this the healthcare system will need to be organised and regulated in the framework of universal access, similar to countries like Canada or Brazil, or more recently our close neighbor Thailand. Of course, India has its own peculiarities and the system that will be designed will have to keep this in mind. We cannot transplant say the Canadian or Costa Rican or Thailand system into India as it is, but we can definitely learn from their experience and adapt useful elements.

Table 2: Per 1000 distribution of hospitalised treatments by type of facility during 1986-87 and 1995-96, India – NSSO

Type of Hospital	Rural			Urban		
	2004 (60th Rd.)	1995-96 (52nd Rd.)	1986-87 (42nd Rd.)	2004 (60th Rd.)	1995-96 (52nd Rd.)	1986-87 (42nd Rd.)
Public hospital		399	554		418	595
PHC / CHC		48	43		9	8
Public Dispensary		5	-		4	-
All govt. sources	417	438	597	382	431	603
Private hospital		419	320		410	296
Nursing home		80	49		111	70
Charitable institution		40	17		42	19
Others		8	17		6	12
All non-govt. sources	583	562	403	618	569	397
all hospitals	1000	1000	1000	1000	1000	1000

Source: NSSO (1998): Report No 441 on Morbidity and Treatment of Ailments, NSS, GOI; NSSO (2006): 60th Round -2004

Table 3: Percentage distribution of non-hospitalised treatments by source of treatment during 1986-87 and 1995-96, India – NSSO

Source of Treatment	Rural		Urban	
	1995-96 52nd Rd.	1986-87 42nd. Rd.	1995-96 52nd Rd.	1986-87 42nd. Rd.
Public hospital	11	18	15	23
P.H.C. / C.H.C.	6	5	1	1
Public dispen.	2	3	2	2
ESI doctor, etc.	0	0	1	2
All govt. sources	19	26	20	28
Private hospital	12	15	16	16
Nursing home	3	1	2	1
Charitable inst.	0	0	1	1
Private doctor	55	53	55	52
Others	10	5	7	3
All non-govt. sources	81	74	80	72
Total	100	100	100	100

Source: NSSO (1998): Report No 441 on Morbidity and Treatment of Ailments, NSS, GOI

Table 4: Health Expenditure as % of Govt Expenditure in HSDP States

State	1987	1998	2006	2010#
Andhra Pradesh	7.88	5.44	3.57	3.8
Karnataka	8.23	5.85	3.73	3.1
Maharashtra	9.38	4.29	3.55	2.8
Orissa	8.50	4.82	4.34	5.0
Punjab	10.52	4.93	3.31	3.1
Rajasthan	14.48	7.97	4.65	5.2
Tamil Nadu	10.04	6.28	4.76	4.8
Uttar Pradesh	9.08	6.03*	4.94	5.3
West Bengal	9.73	6.43*	4.78	4.5

* Data for 1996; # Budget Estimate; source: RBI State Finances

III. Failed health policy making

On the eve of Independence we had an excellent health policy and plan outlined by the Bhore Committee. The formation of this committee marked the first large-scale undertaking to document the prevailing health conditions in India and recommend a plan for the future. The four-volume Bhore Committee Report was submitted to the Government of India in 1946. It defined eight objectives for its plan for a National Health Service: making adequate provision for the preventive and curative medical care; placing services as close to the community as possible; providing widest possible basis of cooperation between health personnel and the people; enabling involvement of medical and auxiliary professions in health policy formulation; making available diverse diagnostic, treatment, laboratory and institutional facilities ('group' practice); making special provisions for vulnerable population groups; providing access to healthcare services irrespective of ability to pay for them; and creating healthy homes, workspaces and recreational facilities (Bhore, 1946).

It emphasised a need for a comprehensive and universal health care system, and it made recommendations concerning the district health scheme and health organization to provide integrated health services - curative, preventive and promotive - to the entire population. If implemented,

these measures would have been India's first steps on the path to universal access to healthcare.

Although the opportunity to build a foundation for universal access to health was presented, the development paradigm had no space for such provisions. Indeed, there was no attempt in the post-colonial period to radically restructure the health care system, as per the framework provided by the Bhore Committee. Rather, a series of five-year plans were instituted which seemed to allow the health care inequalities to continue to grow. Access opportunities favored urban populations, doctors were trained for the private sector through state financing, and bulk drugs were supplied at subsidised rates to private formulation units; both measures facilitated the development and strengthening of the private health sector in India.

In the 1950s and 1960s, India's health sector was focused on managing epidemics. Mass campaigns were started to control diseases such as malaria, smallpox, tuberculosis, leprosy, filaria, trachoma and cholera (Banerji, 1973). During the First (1951-56) and Second (1956-61) Five-year Plans, the basic structural framework of the public health care delivery system remained unchanged. Urban areas continued to receive more than three-fourths of the medical care resources while rural areas received 'special attention' under the Community Development Program (CDP).[5] The Third Five-year Plan (1961-66), discussed the problems affecting the provision of primary health centers (PHC). It directed attention to the shortage of health personnel, delays in the construction of PHC buildings, and inadequate training facilities for staff required in the rural areas (Planning Commission, 1968, p. 657). It also pointed to the inadequacy of health care institutions, doctors and other personnel in rural areas, cited as the major shortcomings of the previous five-year plan (Planning Commission, 1968, p. 652). However, no mention was made of specific steps to reach this goal.

[5] Clear evidence that as early as the beginning of the 1960s the availability of medical care in urban India was already well within the WHO's acceptable standard norm of one hospital bed per 500 persons, whereas rural India was 16 times worse off with regards to these data.

With the Fifth Five-year Plan (1974-79), the government acknowledged that the urban health infrastructure was expanding at the cost of the rural sectors (Planning Commission, 1974 p. 234). Yet it was only in the Sixth Five-year Plan (1980-84), including the announcement of the first National Health Policy (NHP) in 1983, that the transformation of India's rural health infrastructure finally happened.

National Health Policy of 1983

Until 1983, there was no formal health policy. As a consequence of the global debate on alternative strategies during the 1970s, the signing of the Alma Ata Declaration on primary health care in 1978, and the recommendations of the ICMR-ICSSR Joint Panel in 1980 (ICSSR and ICMR, 1980), the government decided that "an integrated, comprehensive approach towards the future development of medical education, research and health services" was necessary (MOHFW, 1983, p.1). During the decade following the 1983 NHP, rural health care received special attention. A massive program of PHC facilities expansion was undertaken in the Sixth (1980-84) and Seventh (1985-90) Five-year Plans to achieve the target of one PHC per 20,000-30,000 people and one sub-center per 2,500-5,000 people.

During the Eighth Five-year Plan (1992-97), a committee to review India's public health status discovered a resurgence of communicable diseases and a need to drastically improve disease surveillance. The Ninth Five-year Plan (1997-2002), incorporated this committee's recommendations, and, in addition to improving disease surveillance, for instance, it addressed the health care worker shortage through part-time positions and state-specific strategies (Planning Commission, 2003, p. 458). The Child Survival and Safe Motherhood (CSSM) program, transformed into the Reproductive and Child Health (RCH) program on the basis of the ICPD-Cairo agenda, received multi-agency external funding support to provide need-based, demand-driven, high quality integrated reproductive and child health care (Planning Commission 2003, pp 519, 557). The Ninth Plan also recommended a reformulation of the 1983 NHP, with a focus not only on improving health care, but also on measuring and monitoring of the health care delivery systems and the health status of the population (Planning Commission, 2003, p. 503).

The Tenth Five-year Plan (2002-07) (Planning Commission, 2003) coincided with the National Health Policy of 2002 (MoHFW, 2002), which, for the first time, was drafted with feedback from the public. The 2002 NHP acknowledged that the public health care system falls grossly short of defined requirements, the morbidity and mortality due to easily curable diseases were unacceptably high, and resource allocations are generally insufficient. It also found public health infrastructure unsatisfactory; insufficient funding for the outdoor medical facilities; insufficient medical and para-medical personnel; unavailability of consumables; dilapidated, obsolescent and unusable equipment in many public hospitals; obsolete equipment and minimal availability of essential drugs in the in-door treatment facilities; all of which leads to "overcrowding, and consequentially to a steep deterioration in the quality of the services" (MOHFW, 2002). The 2002, NHP attempted to regulate the private health sector through statutory licensing, and for expressing concerns for establishing a viable referral system, teaching health volunteers simple medical skills, and improving overall health statistics are also admirable. However, ultimately, the 2002 NHP was a collection of unconnected statements, a dilution of the role of public health services and an unabashed promotion of the private health sector.

The Eleventh Five-Year Plan (2007-2012), like its predecessor, paints a dismal picture of the health services infrastructure in India and stresses the importance of investment in primary health and decentralisation. The specific objectives in the health sector are to reduce infant mortality rate to 28, maternal mortality ratio to 1 per 1,000 live births, and total fertility rate to 2.1; to provide clean drinking water for all by 2009; and to halve malnutrition among children under 4 years and anaemia among women and girls by 2012. The 11th Plan was guided by the National Rural Health Mission (NRHM), which was launched with the 2005-06 budget "to provide effective healthcare to the poor, the vulnerable and to marginalised sections of society throughout the country" (MOHFW 2005). It refers to 18 states as the focus area. This focused approach, however, conflicts with the principle of universal access, thus undermining the very objective of a national health program. It is evident from the history of program implementation in India that targeted programs fail to make an impact as compared to

universalised initiatives.[6] While these groups need special support from the public health system, the goal of the program should not be selective because in doing so it distorts the design of universal coverage.

Since universal access to comprehensive primary healthcare and referral services is not stated clearly as a goal, the financing strategy for NRHM consists of "selective programs for targeted populations." Hence separate schemes like Rs. 10,000 for untied funds for the subcentres, Rs. 100,000 for rural hospital maintenance if Rogi Kalyan Samitis are formed, Rs. 750,000 per block for training ASHAs (village level health workers referred to as Accredited Social Health Activists) etc. have been worked out, instead of determining what resources would the proposed package of comprehensive services require in order to implement it effectively.

Thus NRHM so far has been merely tinkering with the system. It has not made any significant structural inroads to making the architectural changes it proudly boasts about in the mission document. This is because while the government on the one hand talks about NRHM, on the other, it is letting the corporate sector, including multinationals, have an unregulated and open environment to boost the private health sector and profit from it. In fact, NRHM also promotes public-private-partnerships aggressively and a number of initiatives in this line have been launched, the most talked about being the Chiranjeevi scheme in Gujarat for deliveries in private hospitals but financed by government, Rogi Kalyan Samitis, handing over of PHCs/CHCs to private sector/NGOs in Arunachal Pradesh, Gujarat and Karnataka, contracting out of specific services in hospitals like laundry, diagnostic, security, catering services, etc. Further, the use of the insurance route to finance tertiary and secondary care for below poverty line populations through programs like the Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme) and its state level clones like Arogyashri in Andhra Pradesh, Yeshaswini in Karnataka, Jeevan Dayi in Maharashtra etc. are directing huge resources from the Ministries of Health

6 A classic example is the Public Distribution System in India which worked perfectly well until it was universal but by making it targeted to the poor it was destroyed. Similarly introduction of user fees in public hospitals, with a provision that poor would get free access actually destroyed the public hospitals because they were now viewed as hospitals for the poor and the middle class moved away and thus these hospitals lost the voice that made them credible institutions.

– in 2010-11 Rs. 21.98 billion as premiums for 189 million insured persons (IRDA, 2012) - towards such care in the private sector. So an increasing proportion of public resources are being directed for the benefit of the private health sector in addition to various subsidies which already exist[7].

The government is now reviewing this in its preparation for the 12th Five Year Plan and there has been a substantial debate on pushing hard for universal coverage for healthcare. In this context the Planning Commission set up an independent High Level Expert Group (HLEG) to make recommendations for realising Universal Coverage. The HLEG has come up with broadly acceptable recommendations after wide ranging consultations and debates (Planning Commission, 2012). But very little of this has found its way into the 12th Five Year Plan. Again selective solutions like free medicines in all public facilities, health insurance cover for hospitalizations and the like are being pursued as mechanisms to what the Planning Commission calls universal coverage.

IV. Towards a new financing strategy

Currently India's health financing mechanism as mentioned earlier is largely out-of-pocket and one sees a declining trend in public finance. Table 5 indicates trends in health expenditures over the last three decades. It is quite evident from the data that public finance of healthcare is weakening and private expenditures becoming even larger. This needs to change.

First, within the existing public finance of healthcare, macro policy changes in the way funds are allocated can bring about substantial equity in reducing geographical inequities between rural and urban areas. Presently (2010), the central and state governments together spend Rs.550 per capita, but this is inequitably allocated between urban and rural areas. The rural healthcare system gets only Rs.300 per capita and urban areas get Rs.1300

7 Some of the prominent subsidies to private health sector include medical education with 80% of graduates from public medical schools joining the private sector, tax waivers to Trust/Society managed hospitals which do not reciprocate the legal responsibilities of treating 10-20% poor patients free of cost, supply of patients paid by the public sector to corporate hospitals like Apollo, Escorts etc., tax rebates for import of medical equipment and supplies…

per capita, a difference of over 4½ times[8]. If allocations are made using the mechanism of global budgeting, as is done in Canada for instance, that is on a per capita basis then rural and urban areas will both get Rs.550 per capita. This will be a major gain, nearly two times, for rural healthcare and this can help fill gaps in both human and material resources in the rural healthcare system. The urban areas in addition have municipal resources, and of course will have to generate more resources to maintain their healthcare systems which at least in terms of numbers (like hospital bed: population ratios and doctor: population ratios) are adequately provided for. Global budgeting also means autonomy in how resources are used at the local level. The highly centralised planning and programming in the public health sector will have to be done away with and greater faith will have to be placed in local capacities.

Second, the public exchequer even today contributes substantially to medical education to the extent that nearly 80% of medical graduates are from public medical schools. This is a major resource that is not fully utilised. Since medical education is virtually free in public medical schools the state must demand compulsory public service for at least three years from those who graduate from public medical schools as a return for the social investment[9]. Today only about 15% of such medical graduates are absorbed in the public health system. Infact, public service should be made mandatory also for those who want to do post-graduate studies (as many as 55% of MBBS doctors opt for post-graduate studies).

Third, the governments can raise additional resources through charging health cesses and levies on health degrading products (if they cannot ban them) like cigarettes, beedis, alcohol, paan masalas and guthka, personal vehicles etc. For instance tobacco, which kills 670,000 people in India each year, is a Rs.450 billion industry and a 2% health cess would generate Rs.9 billion annually for the public health budget. Similarly alcohol, which presently also generates about Rs.450 billion in revenues, can also bring

[8] These estimates are calculated by the author based on an assessment that the rural healthcare system effectively gets one-third of the budgetary resources.

[9] To train one MBBS doctor the government spends between Rs. 15 and 20 lakhs and thus has every right to expect a minimal amount of public service in return.

in substantial resources if a 2% health cess is levied. The same logic can 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 paid by owners. Land revenues and property taxes can also attract a health cess which is earmarked for public health (municipal taxes already have an education cess component).

Fourth, social insurance can be strengthened by making contributions similar to Employee State Insurance Scheme (ESIS) compulsory across the entire organised sector and integrating ESIS, Central Government Health Services etc. with the general public health system. Also social insurance must be gradually extended to the other employment sectors using models from a number of experiments in collective financing like sugar-cane farmers in south Maharashtra paid Re 1 per tonne of cane as a health cess and their entire family was assured healthcare through the sugar cooperative. There are many NGO experiments in using micro-credit as a tool to factor in health financing for the members and their family. Large collectives, whether self-help groups facilitated by NGOs, or self-employed groups like headload workers in Kerala, can buy insurance cover as a collective and provide health protection to its members. At least 60% of the workforce in India has the potential to contribute to a social insurance program.

Table 5: Health Expenditure Trends in India

Year	Total Public Health Expenditure (Rs.billions)	% of GDP	Private Health Expenditure (Rs.billions)	% of GDP	% Private to Total Health Expenditure
1975-76	6.78	0.90	24.66	3.26	78.43
1980-81	12.86	0.99	52.84	4.06	80.43
1985-86	29.66	1.19	90.54	3.61	75.32
1986-87	44.55	1.47	100.00	3.41	69.18
1992-93	64.64	0.74	175.57	2.61	73.09
1993-94	76.81	0.98	195.43	2.50	71.78
1994-95	85.65	0.93	278.59	3.04	76.48
1995-96	96.01	0.89	329.23	3.07	77.42
1996-97	109.35	0.88	373.41	3.00	77.35

Table continue next page

Year	Total Public Health Expenditure (Rs.billions)	% of GDP	Private Health Expenditure (Rs.billions)	% of GDP	% Private to Total Health Expenditure
1997-98	127.21	0.92	458.99	3.30	78.30
1998-99	151.13	0.94	653.40	4.04	81.21
1999-00	172.16	0.96	835.17	4.76	82.91
2000-01	186.13	0.98	981.68	5.18	84.06
2001-02	194.54	0.94	1100.00	5.32	84.90
2002-03	197.32	0.88	1250.00	5.60	86.36
2004-05	258	0.85	1529*	5.3	86.82
2006-07	365	0.91	1854*	5.8	85.19
2007-08	431	0.90	2042*	5.1	84.78
2008-09	519	0.97	2249*	4.24	81.25
2009-10	606	0.99	2477*	4.05	80.34
2010-11	716	0.98	2730*	3.76	79.22
2011-12	878RE	1.00	3007*	3.42	77.40
2012-13	1047BE	1.04	3520**	3.49	77.07

Note: RE=revised estimate, BE=budget estimates

Source: Public: Finance Accounts of Central and State Governments upto 2010-11and RBI's Finances of State Governments, and Union Budget Expenditure statements for subsequent years; Private: CSO – GOI – Private Final Consumption Expenditures, National Accounts Statistics, 2003 (1993-94 series); * Since available PFCE data beyond 2003-04 is only available based on 2004-05 series and not comparable the estimates have been calculated by author for private expenditures based on the ratio difference of PFCE between 1993-94 and 2004-05 series, for example for 2002-03 the 1993-94 series was 1.6 times the 2004-05 series – overall this appears to be an under-estimate for private health expenditure; **author projection

Fifth, other options to raise additional resources could be various forms of innovative direct taxes like a health tax similar to profession tax (which funds employment guarantee) deducted at source of income for

employed and in trading transactions for self-employed. Using the Tobin tax route[10] is a highly progressive form of taxation which in an increasingly service sector based economy can generate huge resources without being taxing on the individual as it is a very small amount of deduction at the point of transaction. What this basically means is that for every financial transaction, whether cheque, credit card, cash, stock market, forex etc. a very small proportion is deducted as tax and transferred to a fund earmarked for social sector. For example if 0.025% is the transaction tax then for every Rs.100,000 the transaction tax would be a mere Rs.25 or one paise per Rs.40 transacted. This would not hurt anyone if it were made clear that it would be used for social sectors like health, education, public housing, social welfare etc. Infact where the stock market is concerned, which is anyway speculative in nature, a one percent transaction charge on the daily turnover of Rs.1500 billion could net in close to 8% of GDP annually. So in this era of high economic growth raising additional resources is not the issue it is the lack of political will to prioritize healthcare which is the concern.

The above are just few examples of what can be done within the existing system with small innovations. But this does not mean that radical or structural changes should not be done. Ultimately if we have to assure universal access with equity then we have to think in terms of restructuring and reorganising the healthcare system using the rights-based approach. This requires a multi-pronged strategy of building awareness and consensus in civil society, advocating right to healthcare at the political level, demanding legislative and constitutional changes, and regulating and reorganising the entire healthcare system, especially the private health sector.

Thus we have to stem the growing out-of-pocket financing of the healthcare system and replace it with a combination of public finance and various

[10] A Tobin tax, suggested by Nobel Laureate economist James Tobin, was originally defined as a tax on all spot conversions of one currency into another. The tax is intended to put a penalty on short-term financial round-trip excursions into another currency. The term now has sometimes been used interchangeably with a specific currency transaction tax (CTT) in the manner of Tobin's original idea, and other times it has been used interchangeably with the various different ideas of a more general financial transaction tax (FTT).

collective financing options like social insurance, collectives/common interest groups organising collective funds or insurance. At another level the healthcare system needs to be organised into a regulated system that is ethical and accountable and is governed by a statutory mandate, which pools together the various collective resources and manages autonomously the working of the system towards the goal of providing comprehensive healthcare to all with equity. This will happen only if the entire healthcare system, public and private, is organised under a common umbrella through a single-payer mechanism which operates in a decentralised way.

V. Reorganising the health system

The conversion of the existing system into an organised system to meet the requirements of universality and equity and the rights based approach will require certain hard decisions by policy-makers and planners. We first need to spell out the structural requirements or the outline of the model, which will need the support of legislation. More than the model suggested hereunder it is the expose of the idea that is important and needs to be debated for evolving a definitive model.

The most important lesson to learn from the existing model is how not to provide curative services. We have seen above (Table 2 and 3) that curative care is provided mostly by the private sector, and it is completely uncontrolled and unregulated. The system operates more on the principles of irrationality than medical science. The pharmaceutical industry is in a large measure responsible for this irrationality in medical care. Twenty thousand drug companies and over 60,000 formulations characterise the over Rs. 1000 billion drug industry in India.[11] The WHO recommends less than 300 drugs as essential for provision of any decent level of health care. If good health care at a reasonable cost has to be provided then a mechanism of assuring rationality must be built into the system. Family medical practice, which is adequately regulated, along with referral support, is the best and the most economic means for providing good health care. What follows is an illustration of a mechanism to operationalise the right to healthcare, it should not be seen as a well defined model but only as

[11] In addition to this there is a fairly large and expanding ayurvedic and homoeopathy drug industry estimated to be over one-third of mainstream pharmaceuticals

an example to facilitate a debate on creating a healthcare system based on a right to healthcare approach. This is based on learnings from experiences in other countries which have organised healthcare systems, providing near universal health care coverage to its citizens.

Family practice

Each family medical practitioner (FMP) will on an average enroll 400 to 500 families; in highly dense areas this number may go up to 800 to 1000 families and in very sparse areas it may be as less as 100 to 200 families. For each family/person enrolled the FMP will get a fixed amount from the local health authority, irrespective of whether care was sought or no. He/she will examine patients, make diagnosis, give advice, prescribe drugs, provide contraceptive services, make referrals, make home-visits when necessary and give specific services within his/her framework of skills. Apart from the capitation amount, he/she will be paid separately for specific services (like minor surgeries, abortions, deliveries, home-visits, etc.) he /she renders, and also for administrative costs and overheads. The FMP can have the choice of either being a salaried employee of the health services (in which case he/she gets a salary and other benefits) or an independent practitioner receiving a capitation fee and other service charges. The FMPs will work under the oversight of the health district which would roughly be a block in rural areas and a ward in municipal areas.

Epidemiological services

The FMP will receive support and work in close collaboration with the epidemiological station (ES) of his/her area. The present PHC setup will be converted into an epidemiological station. This ES will have one doctor who has some training in public health (one FMP, preferably salaried, of the ES area can occupy this post) and a health team comprising of a public health nurse and health workers and supervisors, social workers/ counsellors and other paramedic and support staff will assist him/her. Each ES would cover a population between 10,000 to 50,000 in rural areas depending on density and distance factors and even up to 100,000 population in urban areas. On an average for every 2000 population there will be a health worker and for every four health workers there will be a supervisor. The main tasks of ES will be Epidemiological surveillance,

monitoring, taking public health measures, laboratory services, information management, counseling services etc. The health workers will form the survey team and also carry out tasks related to all the preventive and promotive programs (disease programs, MCH, immunization, pathology tests etc.) They will work in close collaboration with the FMP and each health worker's family list will coincide with the concerned FMPs list. The health team, including FMPs, will also be responsible for maintaining a minimum information system, which will be necessary for planning, research, monitoring, and auditing. They will also facilitate health education. Of course, there will be other supportive staff to facilitate the work of the health team.

First level referral

The FMP and ES will be backed by referral support from a basic hospital at the 50,000 to 100,000 population level. This hospital will provide basic specialist consultation and inpatient care purely on referral from the FMP or ES, except of course in case of emergencies. General medicine, general surgery, paediatrics, obstetrics and gynaecology, ophthalmology, dental services, radiological and other basic diagnostic services and ambulance services should be available at this basic hospital. This hospital will have 50 beds, the above mentioned specialists, 6 general duty doctors and 18 nurses (for 3 shifts) and other requisite technical (pharmacists, radiographers, laboratory technicians etc..) and support (administrative, statistical etc..) staff, equipment, supplies etc. as per recommended standards. There should be two ambulances available at each such hospital. The hospital too will maintain a minimum information system and a standard set of records. These first level referral hospitals will be supported by higher level secondary and tertiary/teaching hospitals located in larger towns, district headquarters and cities.

Pharmaceutical services

Under the recommended health care system only the essential drugs required for basic care as mentioned in standard textbooks and/or the WHO essential drug list should be made available through pharmacies contracted by the local health authority. Where pharmacy stores are not available within a 2 km. radial distance from the health facility the FMP should have the

assistance of a pharmacist with stocks of all required medicines. Drugs should be dispensed strictly against prescriptions only and completely free of cost to the patient.

Rehabilitation and occupational health services

Every health district must have a centre for rehabilitation services for the physically and mentally challenged and also services for treating occupational diseases, including occupational and physical therapy.

Managing the health care system[12]

For every 3 to 5 units of 50,000 population, that is 150,000 to 250,000 population, a health district should be constituted (Taluka or Block level in rural areas and municipal ward in urban areas). This will be under a local health authority that should comprise of a committee including political leaders, health bureaucracy, and representatives of consumer/ social action groups, ordinary citizens and providers. The health authority will have its secretariat whose job will be to administer the health care system of its area under the supervision of the committee. It will monitor the general working of the system, disburse funds, generate local fund commitments, attend to grievances, provide licensing and registration services to doctors and other health workers, implement CME programs in collaboration with professional associations, assure that minimum standards of medical practice and hospital services are maintained, facilitate regulation and social audit etc... The health authority will be an autonomous body under the oversight of the State Health Department. The FMP appointments and their family lists will be the responsibility of the local health authority. The FMPs may either be employed on a salary or be contracted on a capitation fee basis to provide specified services to the persons on their list. Similarly, the first level hospitals, either state owned or contracted private hospitals[13], will function under the supervision of the

[12] The discussion in this paper is restricted to primary care services but they are not the only component of the core content; higher levels of care are needed as support and these already exist to a fair extent though they need to be reorganised. Thus district level hospitals and metropolitan and teaching hospitals are also part of the core content.

[13] Once contracted in private hospitals as well as FMPs will become part of the public system and will not be allowed any private practice.

local health authority with global budgets. The overall coordination, monitoring and canalisation of funds will be vested in a National Health Authority. The NHA will function in effect as a monopoly buyer of health services and a national regulation coordination agency. It will negotiate fee schedules with doctors' associations, determine standards and norms for medical practice and hospital care, and maintain and supervise an audit and monitoring system. It will also have the responsibility and authority to pool resources for the organised healthcare system using various mechanisms of tax revenues, social and national insurance funds, health cess etc.

Licensing, registration and CME

The local health authority will have the power to issue licenses to open a medical practice or a hospital. Any doctor, wanting to set up medical practice or anybody wishing to set up a hospital, whether within the universal health care system or outside it will have to seek the permission of the health authority. The licenses will be issued as per norms that will be laid down for geographical distribution of doctors. The local health authority will also register the doctors on behalf of the medical council. Renewal of registration will be linked with continuing medical education (CME) programs which doctors will have to undertake periodically in order to update their medical knowledge and skills. It will be the responsibility of the local health authority, through a mandate from the medical councils, to assure that nobody without a license and a valid registration practices medicine and that minimum standards laid down are strictly maintained.

To facilitate the above suggested reorganisation an Act of Parliament backed by a detailed legislation mandating the organised healthcare system as well as its financing mechanisms will have to be put in place. This is not going to be easy because we are not talking of the public health system alone but also of the private health sector which needs to be factored within this reorganisation under a single umbrella of a National Health Authority and financed through a single-payer mechanism of pooled resources. The organisational structure should not be centralised agency but should be functioning autonomously in a decentralised way.

Provision of healthcare services is indeed amenable to decentralisation if there is adequate political will and faith in local communities to take their own decisions. To do this we have to move out of the framework of national programs and a program based approach. Instead the approach as suggested by the 1982 National Health Policy of universal comprehensive healthcare is what we need to adopt in provisioning of healthcare services. Here we will attempt to spell out a framework for such an approach which would function on principles of decentralisation. Today we do have an opportunity to plan differently. The HLEG report has opened an opportunity to engage with universal access to healthcare under NRHM (now NHM) and a lot of discussion and debate is taking place. The unfortunate part of this mission approach is that the executives from the Centre, who are far removed from the grassroots reality, are trying to shape this mission from their perspective rather than that from where the services will be located.

In order to change this, the first thing we need to do is to start understanding that 'decentralisation' is not something to romanticise. Decentralisation should not become a holy cow and we go to the other extreme and say that "people's health in peoples' hands". This is not decentralisation but abdication of responsibility. Provision of healthcare has a logic and scale of its own and hence the basic unit of healthcare provision need not necessarily coincide with the administrative/revenue unit. The health district must be independent of the administrative units. Secondly, we have to keep in mind that healthcare access, especially ambulatory care has to be in easy local reach. This is a very critical issue for rural areas. Unlike urban areas which have high density of population, rural communities are scattered and hence provision of clinical services at very close distance in most rural areas becomes problematic and hence innovative approaches are needed. It is here that the community health model has a role to play but again we must be pragmatic and not romanticise community health as it is unfortunately being done. Community health workers within compact habitats are important first contact persons for health promotion and limited curative care. They are critical link workers within communities where access to the first clinical or epidemiological unit is relatively remote.

In terms of scale of operations as discussed earlier a clinical unit (FMP) for an average of 400 to 500 families and an epidemiological unit at

10,000 population level seems the best option in planning decentralised health services. This means that a PHC functioning as an ES at the 10,000 population level with 4 FMPs (for clinical services, and not necessarily employed by the state) and one Public Health Nurse (for the epidemiological unit) along with the required paramedical and support staff becomes the primary unit for health planning and provisioning. Five to ten such units, depending on population density, would form the health district (between 50,000- 100,000 population) which would have the equivalent of the Community Health Centre as the first level referral unit and this should be governed by a committee (Standing Health Committee) of the panchayat members of that population unit, who should employ/contract the providers and monitor and regulate them. This committee, with secretarial/technical support from the providers, would be the planning unit for the health district and control the health resources which should be allocated to them on a per capita basis by the state government from their health budget. This comprehensive decentralised unit if optimally provided should take care of 80 - 90% of healthcare needs of the population and this would in turn help decongest the district and tertiary hospitals which would become primarily referral centres. The community under each such unit would have to be enrolled (like the NHS in Britain) with the unit and it would be the unit's responsibility to look after their members' healthcare needs, including referral demands for higher level care. This would then become a rights based entitlement for the community and the unit would be accountable to it to deliver, failing which it would be violation of their rights. Of course this system will have to be mandated by legislation and provided adequate resources which estimates show would not exceed the commitment of 2 to 3% of GDP as promised in the Common Minimum Program of the present coalition government at the Centre, though in the long run it would have to be closer to 5% of GDP to be really comprehensive. Such a decentralisation strategy cannot be done by political (policy) action alone but requires concerted effort at reorienting and organising the present unregulated healthcare system into an organised entity which is governed by a well defined regulatory mechanism as well as is socially audited. Such a strategy will also require fiscal and planning autonomy to local governments who should be given the resources on a per capita basis and be left alone to decide how the resources are best used for their community's welfare.

VI. Conclusions and Recommendations

To conclude it is important to re-emphasise that healthcare is a public or social good and cannot be left to the vagaries of the market. To realise its social or public value it has to be organised and regulated using both public and private resources for social benefit. Further, healthcare cannot be planned at the central or state level but has to be decentralised at an appropriate community level as discussed above. The role of the centre and state is thus to strategise such actions, mobilise and disburse resources and monitor its outcomes. The planning and provision functions (who, how, where) are best left to local governance under community vigilance. Such is the global experience where healthcare is universally accessible with equity. Post 1991 countries like Brazil, Venezuela, Mexico, Malaysia, Thailand etc. have moved closer to universal access, so there is no reason why India should not.

In the context of the above discussions given below are some recommendations as part of the progressive realisation of making the architectural corrections which the NRHM framework talked about. These would be radical reforms requiring restructuring and organisation of the entire health sector, including the private health sector. Such restructuring will be possible only if-

- The healthcare system, both public and private, is organised under a common framework which provides access to all without any barriers
- The financing mechanism of healthcare is pooled and coordinated by a single-payer system
- The decision-making and planning of health services is decentralised within a local governance framework
- The healthcare system is subject to continuous community monitoring and social audit under a regulated mechanism which leads to accountability across all stakeholders involved

In order to accomplish the restructuring that we are talking about the following modalities need to be in place:

- All resources, financial and human, should be transferred to the panchayats and municipalities

- The district/municipality will work out a detailed district plan which is based on local needs and aspirations and is evidence based within the framework already worked out under NRHM with appropriate modifications
- The private health sector of the district will have to be brought on board through appropriate contracting in and payment mechanisms as they will form an integral part of restructuring of the healthcare system
- An appropriate regulatory and accreditation mechanism which will facilitate the inclusion of the private health sector under the universal access healthcare mechanism will have to be worked out
- Developing a monitoring and audit mechanism and training key players to do it

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