Medicine and Society

User charges as a feature of health policy in India: A perspective

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INTRODUCTION

The policy of levying charges on people seeking healthcare, which requires people to pay before receiving care, has been a contentious issue among health policy-makers and people working in the health sector. The impact of user charges on the health of a nation merits serious consideration.

The past two to three decades have been the era of globalization and liberalization, with market forces enjoying unparalleled sway globally. Guided by the World Bank (WB) and International Monetary Fund (IMF), the governments of developing countries implemented a 'structural adjustment programme' (SAP) encompassing various sectors of the economy, including the social sector. Increased privatization, fewer government controls and decreased State spending on social sectors (including health) were the main features of the SAP.

The WHO defined health sector reform as a 'sustained process of fundamental change in policy and institutional arrangements of the health sector, usually guided by the government. The process lays down a set of policy measures covering the 4 core functions of the health system, viz. governance, provision, financing and resource generation. It is designed to improve the functioning and performance of the health sector and ultimately the health status of the people.'[1] Thomson (as quoted in *Health sector reforms in India: Initiatives from nine states*)[2] classified reforms as:

Changes in financing methods

1. User charges,
2. Community financing schemes,
3. Insurance,
4. Stimulating private sector growth, and
5. Increased resources to health sector.

Changes in health system organization and management

1. Decentralization,
2. Contracting out of services, and
3. Reviewing the public–private mix.

Public sector reform

1. Downsizing the public sector,
2. Improving productivity,
3. Introducing competition,
4. Improving geographical coverage,
5. Increasing the role of the local government, and
6. Targeting the role of the public sector through packages of essential services.

The reforms brought about a paradigm shift in the health policy, from equity (as emphasized by the Bhore Committee in 1946) to efficiency and from universal coverage to 'exclusion'. User charges are an important source of 'financing and resource generation', which, in their wake, have brought about 'change'. The National Health Policy, 2002 built a case for levying and expansion of user charges in public health services. The policy 'recognizes the practical need for levying reasonable user charges for certain secondary and tertiary public health care services, for those who can afford to pay.'[3]

THE ORIGIN OF USER CHARGES

The shift in policy towards imposition of user charges was a result of WB advice to Third World countries. The 1987 WB report, *Financing health services in developing countries: An agenda for reform,* underscored the need for improved health sector financing. The WB placed health financing at the centre of its dialogue with borrowers and proposed 4 reforms: (i) implementation of user charges at government health facilities as an instrument for mobilizing resources, (ii) introduction of insurance or other risk coverage, (iii) use of non-governmental resources in a more effective manner, and (iv) introduction of decentralized planning, budgeting and purchasing for government health services.[4] The *World Development Report*, 1993 of the WB added emphasis to the implementation of user fees for affluent patients using government health facilities. It also called for the promotion of private and social insurance and competition in the delivery of health services. It redefined the role of governments from one of providing universal healthcare to that of providing essential healthcare.[5] Even though the WB claimed that it did not support user fees, in its 1997 health sector strategy, it maintained that such fees are a tool for mobilizing resources.[6]

Implementation in India

The idea of user charges in India was first mooted in the report of the Health Survey and Planning Committee (chaired by Dr A. Lakshmiswami Mudaliar), submitted in 1961.[7] However, the present scope and form of user charges can be traced back to after the start of the SAP. The Eighth Five-Year Plan (1992–97) stated the need for re-structuring of economic management systems. During this period, the concept of free healthcare was revoked and people were required to pay, even if partially, for health services. This led to the levying of user charges on people above the poverty line for diagnostic and curative services, with free or highly subsidized access for the needy.[2] The Ninth and Tenth Five-Year Plans continued to advocate user charges to meet some of the

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recurring costs in providing such services and to improve the quality of healthcare.[2,8]

User charges were introduced in different states at different points of time. Gujarat and Tamil Nadu are the only states where user charges have not been introduced. At present, user charges are being levied at all district-level hospitals and higher level facilities in the other states. Various primary health centres (PHCs), first referral units (FRUs), district hospitals and medical college hospitals have been handed over to autonomous bodies, such as 'Rogi Kalyan Samitis' (RKS) or corporations, for their day-to-day management.[2,9,10] These bodies are authorized to collect user charges, revise rates from time to time and decide how to spend the revenue so generated.[2,9,10] The forms these arrangements take vary from one state to another, but the result is the same. People possessing certification that identifies them as belonging to the income group 'below the poverty line' are exempted from paying for health services in public facilities, but they get treated in the general ward only. However, the implementation of this rule has been a matter of concern in the administration of the entire user fee structure.

ARGUMENTS SUPPORTING USER FEES

Efficacy in resource generation

User charges have been an important instrument of change in 'financing and resource generation', which has been at the core of health sector reforms. 'Where is the money?' or 'How much and how long can the government provide for free?' is the common refrain of those who believe that implementing user charges is justified. It is also said that people can and will pay for good-quality services but not for poor services, and the problem is not user fees *per se* but the manner in which these are implemented.

We think that the idea of 'free health services' is a myth. While these may be provided free at the point of delivery, the cost is ultimately borne by the patients. Every citizen pays direct or indirect taxes to the government. The government only fulfils its obligations towards people by providing them certain services, including health services. Also, patients still bear the incumbent costs of transportation, food, lodging and consumables, and even informal payments (bribes) to seek expeditious services.[11,12]

Estimates from various studies show that income from user charges amounts to about 5% of total government health spending in most African countries. It is somewhat higher in Asia. In China, it is 36%.[13] The all-India figures for total receipts from revenue generated through user charges were 6.53%, 4.50%, 3.61%, 3.05%, 4.08% and 2.45% of the total health expenditure for the years 1981, 1987, 1991, 1996, 1998 and 1999, respectively (Tables I and II).

The quantum of revenue generated can be increased, as shown

TABLE I. Revenue receipts through imposition of user fees in public health services and family welfare services as a proportion of health expenditure

State	1981	1987	1991	1996	1998	1999
Andhra Pradesh	4.42	1.58	0.31	0.13	0.19	0.13
Arunachal Pradesh	1.83	0.53	0.02	0.06	0.05	na
Assam	0.97	0.18	0.10	0.07	0	0.01
Bihar*	1.34	1.68	0.35	0.27	0.27	0.16
Goa, Daman and Diu	23.84	16.49	0.10	0.68	0.56	na
Gujarat	4.03	0.60	0.89	0.23	0.17	na
Haryana	1.51	2.29	0.12	0.79	0.11	0.15
Himachal Pradesh	1.08	2.07	0.25	0.09	0.04	0.03
Jammu and Kashmir	1.98	1.15	0.02	0.02	0.07	0
Karnataka	1.04	1.15	0.23	0.09	0.12	1.15
Kerala	5.00	0.03	0.16	0.08	0.10	0.11
Madhya Pradesh*	2.36	2.50	0.52	0.48	1.02	0.21
Maharashtra	1.86	0.95	0.70	0.74	0.61	0.73
Manipur	1.58	0.79	1.96	0.13	0.04	na
Meghalaya	0.96	1.63	1.32	0.85	0.16	na
Mizoram	0.17	0.69	0.32	0.10	na	na
Nagaland	0.88	0.39	0.11	0	0	na
Orissa	1.77	2.73	0.20	0.12	0.17	0.11
Pondicherry	4.07	2.12	0.15	0.06	0.07	0.05
Punjab	2.63	1.88	1.28	0.41	0.18	0.07
Rajasthan	17.70	15.06	0.05	0.09	0.06	0.02
Sikkim	0.29	0.50	0	0.31	0.12	0.12
Tamil Nadu	1.10	1.23	0.37	0.28	0.20	0.20
Tripura	0.73	0.78	0.15	0.02	0.03	na
Union Government	2.22	4.44	1.58	1.79	2.84	1.22
Uttar Pradesh*	0.37	0.43	0.31	0.44	1.83	na
West Bengal	0.60	0.33	0.14	0.05	0.37	0.02
All-India	2.86	2.16	0.52	0.43	0.67	0.35

na not available * The data for Jharkhand is included in Bihar, Chhattisgarh in Madhya Pradesh and Uttarakhand in Uttar Pradesh

Sources: The data for 1981 and 1987 are from Combined Finance and Revenue Accounts, Comptroller and Auditor General of India . The data for the other years are from the Demands for Grants of the respective states. The table has been compiled by CEHAT from the above sources. The entry against Union Government shows the collections from services provided by the Central government.

TABLE II. Revenue receipts through imposition of user fees for curative medical services as a proportion of health expenditure

State	1981	1987	1991	1996	1998	1999
Andhra Pradesh	4.37	2.71	3.28	2.23	2.52	2.26
Arunachal Pradesh	1.72	0.09	0.20	0.15	0.51	na
Assam	1.12	0.83	1.68	1.17	1.08	1.53
Bihar*	5.78	2.64	2.41	1.84	1.84	2.09
Goa, Daman and Diu	1.61	0.63	3.54	5.26	5.14	na
Gujarat	7.34	4.88	8.33	5.96	7.34	na
Haryana	7.63	4.28	7.64	6.40	9.26	5.89
Himachal Pradesh	0.83	0.81	1.94	1.27	1.30	1.54
Jammu and Kashmir	0.77	1.05	0.6	0.78	1.05	1.08
Karnataka	5.25	4.26	4.31	4.30	4.95	0
Kerala	5.90	3.92	4.13	5.93	4.49	3.93
Madhya Pradesh*	0.85	1.18	2.58	1.88	2.44	1.29
Maharashtra	0.62	0.68	1.48	0.98	1.30	0.91
Manipur	16.67	16.31	37.67	23.79	31.13	na
Meghalaya	0	0.51	2.01	1.19	0.40	na
Mizoram	0	0.07	0.78	0.54	na	na
Nagaland	0	0.44	1.58	0.90	0.51	na
Orissa	0	0.48	0.02	0.01	0.01	0
Pondicherry	6.98	2.02	2.55	2.68	2.60	2.98
Punjab	1.43	2.33	1.85	1.35	1.62	1.56
Rajasthan	3.76	2.36	3.66	2.19	3.38	1.88
Sikkim	194.12	82.45	80.97	86.16	79.04	35.30
Tamil Nadu	0	0	0.01	0.03	0.01	0.04
Tripura	0	0.26	0.94	1.02	0.63	na
Union Government	3.23	4.11	1.97	3.09	2.40	2.37
Uttar Pradesh*	3.36	1.00	2.53	1.37	6.76	na
West Bengal	8.63	4.67	4.95	3.61	40.88	3.11
All-India	3.67	2.34	3.09	2.62	3.41	2.10

na not available * The data for Jharkhand are included in Bihar, for Chhattisgarh in Madhya Pradesh and for Uttarakhand in Uttar Pradesh

Sources: The data for 1981 and 1987 are from Combined Finance and Revenue Accounts, Comptroller and Auditor General of India. The data for the other years are from the Demands for Grants of the respective states. The table has been compiled by CEHAT from the above sources. The entry against Union Government shows the collections from services provided by the Central government.

by China. However, we feel that providing universal healthcare is a social need that governments are duty-bound to fulfil. The contributions made by a healthy population to the economic growth of a country will more than compensate for the investments made by the government in securing the health of the people.

As to 'where is the money', India's economy has been growing at 8%–9%. This should provide enough resources for investing in the healthcare of the people. Unfortunately, the majority of under-privileged people have not benefited from India's economic growth. While the affluent minority can now buy healthcare for itself, the poor majority must pay for it because the government will not provide for it.

Another aspect worth considering in the context of the funding of public healthcare is the direct and indirect concessions provided by the government to the private healthcare sector. In-depth studies of the quantum of concessions given by the Central and state governments to the private healthcare sector are not available. However, it is apparent that instead of spending on augmenting public health, successive governments have provided public money to facilitate private profits. Large subsidies have been provided to the private sector by releasing prime building land at low rates. The government has provided tax and duty exemptions for importing drugs and expensive medical equipment, and concessions to doctors to set up private hospitals and nursing homes. Moreover, when medical staff trained in public institutions, which charge about Rs 500 (US$ 11) a month, work in private healthcare, it amounts to indirect support to the private sector of about Rs 4000–5000 million per year.[14] Free facilities for poor patients at corporate hospitals are strictly controlled by the top management and are never offered as free service to the poor and destitute! The free beds and facilities are usually reserved for those recommended/related to important people and are traded for political favours.[15] Thus, giving financial concessions to hospitals run by big business houses on the condition that they provide free care to the poor has been an illusion.[16]

Cross-subsidization for the poor

A 'progressive revenue model' and 'constructive user charges' are phrases used to justify the implementation of user charges. It is said that by charging those who can pay, healthcare for the poor can be subsidized. However, the revenue generated from user charges is a tiny percentage of the total health budget and unlikely to make any difference to the provisioning and quality of services. On the contrary, for a large number of people, user charges act as a barrier to accessing health services. Apart from this, there are also instances to show that the money realized through the imposition of user charges lies unutilized.[17] There are reports from public health institutions in different states of money collected

from patients lying unutilized for different reasons. The inability of the administrators to handle such revenues is one of the important reasons.[9] If, indeed, the idea is to make the rich pay for the poor, then why not tax the rich and spend on the poor?

Do user charges enhance accountability?

It is said that health providers become more accountable to users with the levying of charges for their services. The logic is that once a patient pays, he tolerates less inefficiency on the part of the providers. It has been argued that under the neo-liberal phase of capitalism, the dominance of markets restricts consumer power because of limited participation of state institutions in governing exchanges.[18–20] States with investments in welfare programmes and healthcare infrastructure traditionally provided a safeguard and an alternative to a profit-based market system. In the age of liberalization, globalization and privatization, this alternative has been systematically eroded in most of the less developed world, particularly in India.[19] The private health sector in India is largely unregulated. With the state withdrawing itself as the main provider of healthcare, there has been further dilution of safeguards. Thus, it is hard to imagine healthcare providers being more accountable merely because patients pay charges to avail themselves of services.

Accountability is directly related to the social and political empowerment of the people. The state of Kerala provides a clear illustration of this. Kerala is one of the relatively poor states of India, yet its health indicators compare favourably with those of the developed world (Table III).[21] This happened much before the imposition of user charges in health services. Varman and Kappiarath observe, 'Kerala demonstrates that despite having one of the poorest populations in terms of monetary resources, its alternate route of sociopolitical power has enhanced their access to consumption of goods and services… The state of Kerala is definitely under pressure to let neo-liberalization dictate market exchanges. Time alone will show the net impact of these changes on the Kerala healthcare consumer.'[22] There are no indications yet that states which levied user charges first have better healthcare indicators. There are no shortcuts to empowering the people, as far as healthcare is concerned, and user charges can certainly not do so.

IMPROVING EFFICIENCY IN HEALTH SERVICES?

Does levying of user charges lead to greater efficiency in the healthcare system? Does the imposition of user charges lead healthcare providers to exercise diligence in providing only those services which patients require? Sepehri *et al*.[23] reported that with the imposition of user fees and insurance-based healthcare in public health facilities in Vietnam since 1995, the hospital revenues from user charges had increased up to 30% in 1998. Increased reliance of providers on the income from user charges and provision-based bonuses resulted in the replacement of a salary system based on a centrally determined global budget with a poorly regulated fee-for-service system. Growth in revenues from patients resulted in large increases in the intensity of treatment. The increase in the admission rate and length of hospital stay was much higher for the better off than the poor, and greater for the insured than the uninsured. The increase in intensity of hospital care seems to be an attempt on the part of providers to increase revenue from health insurance premiums and user charges in the face of a shrinking share of public resources allocated to hospitals and low salaries.[23] We can add to this our own experience of unnecessary investigations being ordered by physicians, often from private diagnostic centres, on account of long waiting periods in the public hospitals and not infrequently, due to the incentives offered by these centres.

It has been suggested that patients tend to misuse free healthcare facilities and user fees decrease such misuse. In developing countries such as India, where a large proportion of the population is poor, a visit to a hospital or healthcare facility leads to loss of wages.[24] Hence, to argue that someone would misuse a 'free' facility is absurd. The Rand Health Insurance Experiment in the USA further shows the futility of user charges in reducing unnecessary medical costs. In this experiment, patients were assigned to insurance plans with different rates of user charges. People got less medical care in plans with heavier charges because the higher user charges deterred people from availing themselves of medical care. However, the proportion of inappropriate use of antibiotics, hospital stays and admissions was the same—with or without user fees—suggesting that levying charges does not check the inappropriate use of healthcare facilities. It has been shown that user fees help reduce costs in the short term, but eventually lead to more spending because more people would neglect seeking early treatment.[25]

Table III. Comparison of socioeconomic indicators of Kerala with low-income countries (LIC)* and USA

Indicator	Kerala	India	LIC	USA
Per capita GNP (US$)	324	390	350	28 740
Adult literacy (%)	94	65	65	96
Life expectancy (in years)				
Men	67	62	58	74
Women	72	63	60	80
Infant mortality (per 1000 live births)	13	65	80	7

Source: Franke RW, Chasin B. Is the Kerala model sustainable? In: Govindan P (ed). *Kerala: The development experience.* London:Zed Books; 2000:17–39.
* low-income countries as defined by World Bank, excluding China and India.

IMPACT ON ACCESS TO HEALTHCARE

This is perhaps the most vexed issue with respect to the policy of levying user charges. There is evidence from both developed and developing countries that user charges are a barrier to accessing healthcare for most people and especially the poor. The brief experience of user charges in Saskatchewan, Canada showed that vulnerable sections of the population (the elderly and poor) visited their doctors 18% less due to increased costs.[26] The Rand Health Insurance Experiment showed that due to user charges, all people tended to use health facilities less, but the decrease was greater in the case of the poor. It also found that sick people were more likely to die when they had to pay user charges. In the Rand experiment, low-income users decreased their use of healthcare services from 82.8% when they did not have to pay, to 61.7% when user charges were the highest.[25] The findings of a study from Finland suggest that moderate user charges may reduce the demand for paediatric trauma services.[27]

Many studies from developing countries show that user charges act as a barrier to accessing healthcare, especially in the case of the poor.[28–36] User charges further decrease access for the more vulnerable sections among the poor, such as women, children, and the scheduled castes and scheduled tribes in India.[37–39] Some studies report an increased utilization of public healthcare services even among the poor and in rural areas after the introduction of user charges.[9,40–42] It is possible that this is because public health services are cheaper than private healthcare even on payment. Therefore, it is imperative for the government to commit more resources for the healthcare needs of the people to bring about an

improvement in the health status of the people, and hence in their economic performance. This would be more expedient in the economic sense than imposing user charges to generate resources.

EXPERIENCE IN CHINA

China exemplifies how user charges can undo a remarkable success story in the field of public health. In the late 1950s, when China was a poor nation, it developed an innovative system of healthcare—the concept of 'barefoot doctors', who delivered preventive and basic health services to more than 90% of the population.[43] Between 1952 and 1982, China decreased the infant mortality rate from 250 to 40 per 1000 live births and the prevalence of malaria from 5.5% to 0.3% of the population, and increased life expectancy from 35 to 68 years.[44]

Following economic reforms, hospitals and health centres are now required to obtain most of the resources for operations directly from patients, while government funding accounts for 20%–25% of the hospital budget. Health insurance is available to about 25% of the population. The government has also reduced the budget for preventive care and vaccination, so that managers of public health programmes now support their operations with fee-for-service payments.[45]

Access to healthcare in China today is based largely on a patient's ability to pay. For 50% of the rural population, the cost of one hospitalization exceeds the average annual income. In an article published in *The New England Journal of Medicine*,[45] the author quotes unpublished data of a study conducted between 1992 and 1995 that covered 180 villages and 11 042 households. It found that 30% of villages had no doctor; 28% of people did not seek healthcare when ill because they could not afford it; and 51% of those advised hospitalization by a doctor refused to be hospitalized because of the cost. These findings suggest a collapse of community-based healthcare and rapid increase in healthcare costs to be an important cause of poverty in rural China.[45] This has happened in a period of unrestrained economic growth in China.

There is also evidence that the health status of the Chinese has been adversely affected by the economic reforms. Despite rapid economic growth and improvement in the literacy rate, the mortality rate for children under 5 years of age has not changed since 1985, according to a UNICEF report.[46] Infant mortality rates (37 per 1000 live births in urban and 41 per 1000 live births in rural China in 1993) had remained unchanged since the mid-1980s,[47,48] and the average life expectancy had changed little (from 68 years in 1982 to 69 years in 1993).[47] Summarizing the experience of user charges, Segall says, 'Although in certain situations user fees have improved the quality and increased the utilization of primary care services, direct charges deter healthcare use by the poor and can result in further impoverishment. Direct user fees should be replaced progressively by increased public finance and, where possible, by pre-payment schemes based on principles of social health insurance with public subsidization. Priority setting should be driven mainly by the objective to achieve equity in health and well-being outcomes. Cost-effectiveness should enter into the selection of treatments for people (productive efficiency), but not into the selection of people for treatment (allocative efficiency).'[34]

TARGETED OR UNIVERSAL COVERAGE IN HEALTHCARE

In 2000, concerns about the adverse effects of user charges led several non-governmental organizations (NGOs) in the USA to pressure Congress to require the IMF/WB to modify loan conditions for developing countries. In 2004, the WB came up with a 'no blanket policy on user fees' and suggested that free service should be provided unless there was a good reason to charge for it.[49] This suggested that the key issue was to identify the poor who could then receive free service, but if that was not possible, it needed to be decided whether the service could be delivered adequately without user fees for all.[49]

There are problems associated with the identification of the poor. Broadly, two approaches have been used for this purpose, i.e. universal entitlement and targeting. Planners initially chose targeting for special programmes but universal entitlement for basic minimum needs. Economic reforms have removed this distinction, consistent with the overall paradigm of neo-liberal economy. That is why social services, such as the public distribution system (PDS), and the provision of drinking water, sanitation, health services and higher education, have been moved to a 'payment for service' regimen. Those enthusiastic about reforms advocate strict targeting in extending the benefits of subsidized public services, whether health or other welfare measures. The ideological underpinnings of this approach rest on:

1. Identifying eligible or (needy) individuals and screening out the ineligible, according to defined eligibility criteria, for the purpose of transferring resources.[50]
2. Ensuring that the really needy are assisted and the less needy do not benefit unfairly and ensuring that scarce resources are used in such a way that they have the highest impact on the problem to be addressed.[51]

The pro-reform enthusiasts support targeting and consider universal entitlement as wasteful and inefficient. This logic is flawed because while costs can be easily computed, the loss of health, productivity and feeling of 'well-being' are difficult to measure in quantitative terms, and their economic costs may be much higher when compared to the increased financial expenditure.[52] Also, errors in selection could mean the exclusion of the needy, but universal entitlement would mean higher expenditure.

For targeting welfare schemes, people are categorized by the government into two categories: those below the poverty line (BPL) and those above the poverty line (APL). BPL people are entitled to receive the benefits of welfare schemes free. The big question, however, is does targeting work?

Among the problems are issues concerning the making of BPL cards, their renewal and the awareness of the poor of the benefits that these cards entitle them to, as well as exclusion of the deserving and inclusion of those who are not eligible. Also, there is no guarantee that the benefits to which the poor are entitled due to their possession of a BPL card will be made available to them. The very procedure of availing oneself of these benefits is difficult. The policy of targeting can widen social divisions among the poor and lead to social tensions and polarizations. It can exacerbate existing forms of caste and gender oppression.[52] Experience suggests that targeting can pave the way for greater inequality and more poverty.[53]

A 2002 report by INSAAF International, titled 'World Bank Funded Health Care: A Death Certificate for the Poor', is pathognomonic of the state of affairs in India. It reported instances of patients in Punjab being thrown out of public hospitals because they did not have money to pay user charges. User charges were imposed in hospitals of the Punjab Health Systems Corporation from October 1995. The poorest were entitled to exemptions on the basis of government-issued yellow cards, but in Bhatinda (population 270 000), no yellow cards had been made since 1996 and only 44 yellow cards had been renewed since 1998. Not a

single exemption was granted between July and December 2000 at the Bhatinda referral hospital. Only 1 in 150 city slum women had even heard of yellow cards. The researchers reported a 20% reduction in bed occupancy and a 20%–40% reduction in outpatient cases.[54]

The poverty line

This is used for designing the architecture of benefit distribution in development planning. The objective is to reduce the hardship caused by economic inequalities. The poverty line is designed, measured and evaluated across states by the Planning Commission and forms the norm for multiple entitlements to subsidized welfare programmes. Challenges to the estimation of the poverty line are not entertained even from states/other official agencies. The sacrosanct nature of the poverty line, as projected by the Central government, has been the subject of controversy and heated debate in academic circles. Although there is no consensus on what happened to Indian poverty in the 1990s, there is evidence that the official estimates of poverty reduction are too optimistic, particularly for rural India.[55]

The poverty line defined by the Planning Commission for 2004–05[56] and the all-India daily income is about Rs 12 for rural and Rs 18 for urban areas (Table IV). With these cut-offs, it was estimated, based on uniform recall period (URP) consumption/distribution, that 27.5% of people were BPL in 2004–05, while based on the mixed recall period (MRP), 21.8% were BPL. MRP is based on consumption data using a 365-day recall period for 5 infrequent non-food items, namely, clothing, footwear, durable goods, education and institutional medical expenses, and a 30-day recall period for the remaining items, such as food. URP is based on data on household consumption expenditure, using a 30-day recall period (also known as reference period) for all the items.

Further, the International Poverty Line stands at a dollar a day (about Rs 43). According to estimates in the UN Human Development Report, 2008, 34.3% and 80.4% of Indians live on daily incomes of less than 1 and 2 US dollar, respectively.[57] By conservative estimates, the poor spend around 50%–60% of their earnings on food. This leaves about Rs 6, Rs 9 and Rs 22, to be spent on all other expenses (including health) according to the rural, urban and international poverty lines, respectively. Given the costs of modern healthcare, what possible healthcare of any quality can one afford with this income? What about the large number of households with consumption levels close to the poverty line, though not below it? What is the utility and cost-effectiveness of targeting, when large sections of the population are poor or marginally poor?

'Our definition of poverty excludes education, health and sanitation … Hunger keeps rising, per capita availability of food keeps falling, unemployment keeps rising, migration keeps rising, but poverty keeps falling. It is as if poverty has a separate existence, independent of food intake, lifestyle, employment and education.'

—P. Sainath
Rural Affairs Editor
The Hindu
and Ramon Magsaysay awardee, 2007

How just is it to deny healthcare to the poor on the basis of such precepts of poverty?

TABLE IV. State-specific poverty lines in 2004–05 (Rupees per capita per month)

State	Rural	Urban
Andhra Pradesh	292.95	542.89
Assam	387.64	378.84
Bihar	354.36	435.00
Chhattisgarh	322.41	560.00
Delhi	410.38	612.91
Goa	362.25	665.90
Gujarat	353.93	541.16
Haryana	414.76	504.49
Himachal Pradesh	394.28	504.49
Jammu and Kashmir	391.26	553.77
Jharkhand	366.56	451.24
Karnataka	324.17	599.66
Kerala	430.12	559.39
Madhaya Pradesh	327.78	570.15
Maharashtra	362.25	665.90
Orissa	325.79	528.49
Punjab	410.38	466.16
Rajasthan	374.57	559.63
Tamil Nadu	351.86	547.42
Uttar Pradesh	365.84	483.26
Uttarakhand	478.02	637.67
West Bengal	382.82	449.32
Dadra and Nagar Haveli	362.25	665.90
All-India*	356.30	538.60

* The poverty line (implicit) at the all-India level is obtained from the expenditure class-wise distribution of persons based on uniform recall period consumption, that is, consumption data collected from 30-day recall period for all items, and the poverty ratio at the all-India level. The poverty ratio at the all-India level is obtained as the weighted average of the state-wise poverty ratio.
Source: Government of India, Press Information Bureau. Poverty estimates for 2004–05, New Delhi, March 2007

SOCIAL INEQUITIES, PRIVATIZED HEALTHCARE AND THE POOR

The social and economic conditions of society are important determinants of healthcare. Indian society is characterized by gross inequalities and the past 2 decades of economic reforms have aggravated inequalities in income. Studies have documented a strong association between inequalities in income and excess mortality.[58,59] The mortality rate of the poorest 20% of Indians is double that of the richest 20%.[60] The infant mortality rate among the poorest 20% is 2.5 times higher than that among the richest 20%.[61,62] The socioeconomic inequalities have also led to disparities in healthcare between the rich and the poor. With the implementation of the SAP and health sector reforms, the health system in India today caters largely to the needs and demands of the well-off. As a result of the reforms, public services were replaced and emasculated by private provision. This undermined what little remained of comprehensive provision, both at the primary and secondary levels of healthcare. The reforms emphasized selective disease control for the public sector and control of a lucrative curative sector for private providers.[63]

Healthcare has become a commodity. Private healthcare focuses on the maximization of profit, while the public health infrastructure is being subverted to facilitate these profits. In the given scenario, whatever little subsidy is given to public healthcare also serves the interests of the well-off more than those of the poor. A study by the National Council of Applied Economic Research reveals that the share of public subsidy for health enjoyed by the richest 20% is 3 times that enjoyed by the poorest quintile.[64] The most peripheral and vital units of India's public health infrastructure, the PHCs, are being left in the lurch. Surveys have shown that only 38% of all PHCs have essential manpower and only 31% have all

essential supplies (defined as 60% of critical inputs), with only 3% having 80% of all critical inputs.[61] On the other hand, indirect privatization has made inroads into tertiary healthcare facilities in the public sector by way of contracting of services, creation of temporary jobs, almost no provision for drugs and consumables required for treatment, introduction of charges for outpatient cards, admission fees, and charges for diagnostic tests and procedures. There are proposals on and off for introducing schemes such as paid clinics and handing over public sector facilities to the private sector for the provision of services. There is a trend towards paying incentives for the services of health workers, right from the most peripheral worker, the accredited social health activist (ASHA), to doctors. Incentives generate motives of their own and introduce an element of greed for more incentives. It is argued that the resources generated by such creative and ingenious schemes help in cross-subsidizing the care of the poor. This does not take into account the fact that those who pay tend to monopolize public health facilities, pushing the non-paying patients further to the margins. It is even more so when the poor hardly have a say in the policy framework and depend entirely on the wisdom of the government to take care of their interests.

The increasing cost of healthcare that is paid from 'out-of-pocket' payments is making healthcare unaffordable for an increasing number of people. There is a large unmet demand for healthcare due to increase in costs.[64] One in 3 people who need hospitalization and are paying out of pocket are forced to borrow money or sell assets to cover the expenses.[64] Over 20 million Indians are pushed below the poverty line every year because of out-of-pocket spending on healthcare.[65] It is a fact that the private health sector in India is the least regulated. This has resulted in there being no check on the quality of services provided by it. Reliance on a market-based system has contributed to a decline in state health institutions, proliferation of private clinics and a close physician–pharmaceutical firm nexus. Instead of creating a more efficient system of healthcare delivery, market forces are instrumental in the marginalization of the subaltern sections of the population.[66]

CONCLUSIONS

There has been a dichotomy in the professed aims and the *de facto* policies of the government in India with respect to health independence. The welfare state approach towards providing healthcare that was adopted initially was gradually diluted and by the beginning of the mid-1980s, was abandoned in the wake of the World Bank/IMF guided reforms. The private sector that has emerged since the reforms has seen the dominance of market forces in the provision of healthcare in India. This has had a devastating impact on the health of the poor.

The shift towards privatization and the dominance of profit in the health sector have led to a crisis in the healthcare system. This should be of serious concern for health policy-makers and healthcare professionals. User fees do not lead to a more affordable health system, but they do create advantages for the rich and healthy and make matters worse for the sick and poor.

We believe that healthcare professionals, in their day-to-day work encounter the effects of this neo-liberal paradigm of healthcare, whether working in a remote corner of the country or in tertiary healthcare institutions. Healthcare professionals need to be at the forefront to build resistance to market-oriented health policies and to securing the healthcare interests of the vast number of poor in India.

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