Speaking for Ourselves

Healthcare financing: Approaches and trends in India

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ABSTRACT

Despite the importance of healthcare for the well-being of society, there is little public debate in India on issues relating to it. The 'human capital approach' to finance healthcare largely relies on private investment in health, while the 'human development approach' envisages the State as the guarantor of preventive as well as curative care to achieve universalization of healthcare. The prevailing health indices of India and challenges in the field of public health require a human development approach to healthcare. On the eve of Independence, India adopted the human development approach, with the report of the Bhore Committee emphasizing the role of the State in the development and provision of healthcare. However, more recently, successive governments have moved towards the human capital approach. Instead of increasing state spending on health and expanding the public health infrastructure, the government has been relying more and more on the private sector. The public–private partnership has been touted as the new-age panacea for the ills of the Indian healthcare system. This approach has led to a stagnation of public health indices and a decrease in the access of the poor to healthcare.

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INTRODUCTION

People's health is one of the most important determinants of society's overall well-being and economic prosperity. Yet, health is an issue that is largely absent from the public discourse on development in India. It is hard to recall any national or state election in which health issues played an important role. Indeed, successive central and state governments have evaded their responsibility towards the victims of the biggest industrial disaster in the history of the world—the Bhopal gas leak tragedy. Health is discussed in the media, though what draws attention are issues such as India becoming the preferred destination for 'health tourism' and the emerging opportunities in the field of clinical trials—issues which are of interest more to big businesses than the people. The issues of communicable diseases being rampant in large parts of the country, the stagnant infant and mortality rates, and hunger and malnutrition are relegated to the footnotes, if at all they are mentioned.

It is also of concern that healthcare professionals have by and large detached themselves from these important issues. There seems to be a perception that these are more in the realm of politics or economics and best left to the care of those especially skilled to handle them. However, there is a need to unravel these issues in a manner so as to engage the interest of every healthcare professional and the widest possible section of the public.

The policy orientation of India's healthcare delivery system has since long suffered from infirmities that have rendered it deficient in achieving the formidable tasks before it. At a time when policy corrections were needed, the choices made by policy-makers have led the health scenario in India down a blind alley. Developments in the health sector over the past 2 decades have seen an increasing roll back of public healthcare and a much wider role for market forces in the provision of healthcare. The impact of these changes is difficult to ignore. We present a perspective on aspects of the financing of healthcare in India, the imposition of user charges and the status of the poor in the increasingly privatized healthcare system. We hope that this will contribute towards a considered debate and dialogue among healthcare professionals on issues that directly impact upon patients and demand a people-centric healthcare policy.

HEALTHCARE FINANCING

There have been two main approaches towards investment in the social sector, namely the human capital approach and the human development approach.[1] These approaches have specific implications for public policy and social security.

Human capital approach

This approach considers investment in education, health and nutrition as leading to the formation of human capital, a critical mass of which is a means to higher productivity and economic growth. However, such human capital is expected to be built as a product of individual initiatives. Individuals invest in themselves in the expectation of higher returns from such investment in the form of higher private earnings in the future. The State acts merely as a facilitator in the process; its investment is minimal and limited to aspects that yield large positive gains.[2] In the field of public health, this implies that State investment is confined to areas such as the control of communicable diseases, immunization and similar such initiatives that generate large positive gains. The government is not necessarily concerned with providing overall or a minimum level of healthcare with a view to enhancing the health security of its people. Thus, there is greater reliance on private financing of healthcare and domination of the market in the health sector. The availability of healthcare depends on the ability of the people to purchase it. The poorer sections of society are edged out in the process, with their healthcare needs remaining largely unfulfilled and the inequalities between the rich and the poor getting further accentuated.

Human development approach

This approach reflects a paradigm in which education and health are regarded as fundamental rights and the State provides minimum standards of health for the bulk of the population. The entitlement

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of the people to these rights implies that the rates of returns from investment in the social sectors are not a consideration for investment in health, nutrition and education. A greater commitment of the State to social sector spending increases the likelihood of a more integrated policy being adopted so as to provide a minimum level in all social areas, such as education, health, nutrition and housing. In the health sector, it implies the provision of preventive as well as curative services, with the universalization of healthcare being the guiding principle.[3]

For societies with considerable structural inequities, the human development approach makes for a more people-centric social policy. The state would thus fund and support integrated preventive and curative healthcare. As opposed to the human capital approach, the availability of healthcare would not depend upon the purchasing power of the people.

There are differences over which of the two approaches best suits the interests of public healthcare in India. We briefly examine the current public health challenges as a guide to building a case for what we feel would be the right choice.

PUBLIC HEALTH CHALLENGES BEFORE INDIA

Poverty is a big challenge in India—about 20% of those living on less than US$ 1 per person per day globally are in India.[4] The 2004–05 data of the Planning Commission show that over one-quarter of people in India are below the poverty line.[5] Poverty is at the root of many illnesses, such as tuberculosis, respiratory infections, diarrhoea and malaria, which continue to be public health problems in India. Around 500 000 people die every year from tuberculosis, a disease for which free treatment is available through the government.[6]

India has the largest number of undernourished people on the globe.[7] According to the Global Hunger Index rankings for the year 2003, released by the International Food Policy Research Institute, India was ranked 96 out of 119, below Haiti, Gabon, Bolivia, Djibouti and all her South Asian neighbours, with the exception of Bangladesh.[8] According to the Global Hunger Index rankings for the year 2009, released by the International Food Policy Research Institute, India is ranked 65, behind some of the most impoverished sub-Saharan African countries, such as Gabon, Burkina Faso, Ghana, Nigeria, Senegal, Guinea, Cameroon, Malawi and Uganda.[8] At 450 maternal deaths per 100 000 live births, India has among the highest maternal mortality rates among countries with comparable or lower levels of development.[9] In human development indices, India has slipped to 134 in the United Nation's *Human Development Report 2009*, below some of the most impoverished African nations.[10] Disparities in standards between different sections of the population are glaring, as shown by the fact that if we were to isolate the rich and better off sections of Indian society as a group, this section might be at par with the top ten nations. However, a similar assessment for the tribal population in India would place them in the 25 worst off nations.[11]

This would suggest that adopting a human development approach towards the social sectors, including healthcare, would be the right choice. However, there are differences among policy-makers. We examine briefly how the approach to financing healthcare has varied since Independence.

FINANCING HEALTHCARE IN INDIA

Bhore Committee and the origins of health policy

On the eve of Independence in 1947, the Health Survey and Development Committee (also called Bhore Committee), under the chairmanship of Sir Joseph Bhore, made recommendations for the development of the healthcare system in India. These were modelled on the 'welfare state' concept and largely determined the ideological and operative premises of the healthcare system in India. The Bhore Committee supported adopting a human development approach towards healthcare—'Expenditure of money and effort on improving the nation's health is a gilt-edged investment which will yield not deferred dividends to be collected years later, but immediate and steady returns in substantially increased productive capacity'.[12] Interestingly, the Bhore Committee also discussed and clarified other issues that would be extremely relevant today.

Should medical service be free or paid for?

The Bhore Committee held: 'We feel that a very large section of the people are living below the normal subsistence level and cannot afford as yet even the small contribution that an insurance scheme will require. We therefore consider that the medical benefits this scheme will have, in any case, to be supplied free to this section of the population until at least its economic condition is materially improved. We are averse to drawing any line of distinction between sections of the community, which are and are not in a position to pay for such benefits. The application of a "means test" for this purpose is unsatisfactory and may often involve enquiries… We consider, therefore, that for the present medical services should be free to all without distinction and that the contributions from those who can afford to pay should be through the channel of general and local taxation.'[12]

Whole-time salaried medical practitioners or private practitioners

The Bhore Committeee said: 'The absence of certain amenities and services in the countryside has proved a deterrent to medical practitioners leaving the attraction of cities and towns and migrating to the villages. Various attempts have been made to solve the problem. One method, which has been tried in more than one province, has been the settling of medical practitioners in rural areas and giving them a subsidy, which will enable them to start practice. This subsidy was intended to be supplemented by private practice among the richer sections of the community. We have had considerable evidence to show that this method has been far from being an unqualified success, partly because in many villages the income derived from private practice is too small to support the doctor in reasonable comfort. The result has been that, in many cases, the better types of such subsidized doctors have tended to gravitate back to the towns. In areas where there are greater opportunities for private practice, the more prosperous sections of the community have, we are told, generally received greater attention than the poor. We have, therefore, come to the conclusion that the most satisfactory method of solving this problem would be to provide a whole-time salaried service which will enable governments to ensure that a number of representatives of medical associations, individuals and several responsible medical administrators lend strong support to this proposal'.[12]

Further, 'if the poor in the rural areas must receive equal attention and if preventive work must get done, then private practice by whole-time salaried doctors should be prohibited'.[12] Concluding the discussion, the committee said, 'We are satisfied that our requirements can only be met satisfactorily by the development and maintenance of a state health service.'[12] The concept of 'universal health care' was thus the focus of the emerging contours of our health policy on the eve of Independence. The Bhore Committee recommended that state governments should spend a minimum of 15% of their revenues on health activities.

The recommendations of the Bhore Committee were endorsed by the National Planning Committee (NPC) set up by the Indian National Congress in 1938, under the chairmanship of Colonel S.S. Sokhey. Though not as detailed as the Bhore Committee, this committee's report stated that the recommendations of the Bhore Committee were of 'the utmost significance'.[13]

The plan that was set up by the Bhore Committee was to be implemented over the next 30–40 years, i.e. all the recommendations should have been implemented by the early 1980s.[12] It has been estimated that at that time, the capital funds required to implement the Bhore Committee plan was only 1% of the gross domestic product (GDP) and the running expenses of the infrastructure (including amortization of capital expenditure) a mere 1.33% of the GDP.[14]

After Bhore till the emergence of the private sector

Unfortunately, the recommendations of the Bhore Committee were belied in practice from the inception. Against the recommendation of spending 15% of the revenue on health, the First (1951–56) and Second (1956–61) Five-Year Plans allocated only 5% of the total revenue to health expenditure.[15] The budgetary allocations to health continued to remain low through the different plan periods. Except for a brief period in the late 1970s and early 1980s, public healthcare continued to be feeble. There was a general thrust towards higher rates of health expenditure by the government during the mid and late 1970s under the Minimum Needs Programme,[15] and in the 1980s, perhaps as a sequel to accepting the goal of Health for All, contained in the National Health Policy of 1983.[3] This trend was short-lived. The Eighth Plan (1992–97) encouraged private initiatives, and private hospitals and clinics, besides providing suitable returns from tax incentives.

A joint panel of the Indian Council of Social Science Research (ICSSR) and the Indian Council of Medical Research (ICMR) on health was constituted in 1980 to make recommendations for providing comprehensive healthcare. It suggested that public expenditure on health should be at least 6% of the GDP.[16] This recommendation, too, has not been implemented (Table I and Fig. 1). Public spending on health in the states increased from 0.8% of the GDP in 1975–76 to about 0.9% in 2003–04.[17] During 1975–85 public spending on health registered a substantial increase and reached a high of 1.05%. Thereafter, it slowly decreased due to fiscal stress during the late 1980s, followed by the structural adjustment programme (SAP) in the 1990s.[17] When reforms were initiated during the early 1990s, fiscal transfers to the states from the Centre were compressed, leading to reductions in allocation to the health sector (Fig. 2).[17] The sharp decline in capital expenditure led to stagnation in the creation of additional health infrastructure.

According to the *World Development Report*, India's overall expenditure on health (public and private combined) equals nearly 6% of the GDP.[18] The private sector accounts for 4.7% of the GDP (78.5% of total health expenditure)—4.5% is out-of-

TABLE I. All India figures of health expenditure as a percentage of gross domestic product (GDP) and the per capita health expenditure

Year	Health expenditure as a percentage of GDP			Per capita public expenditure on health (₹)
	Revenue	Capital	Aggregate	
1950–51	0.22	na	0.22	0.61
1955–56	0.49	na	0.49	1.36
1960–61	0.63	na	0.63	2.48
1965–66	0.61	na	0.61	3.47
1970–71	0.74	na	0.74	6.22
1975–76	0.73	0.08	0.81	11.15
1980–81	0.83	0.09	0.91	19.37
1985–86	0.96	0.09	1.05	38.63
1990–91	0.89	0.06	0.96	64.83
1995–96	0.82	0.06	0.88	112.21
2000–01	0.86	0.04	0.90	184.56
2001–02	0.79	0.04	0.83	183.56
2002–03	0.82	0.04	0.86	202.22
2003–04	0.86	0.06	0.91	214.62

GDP is at market price with 1993–94 as the base year and includes only Central and state government expenditure na not available

Source: Report of the National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare, New Delhi, 2005.

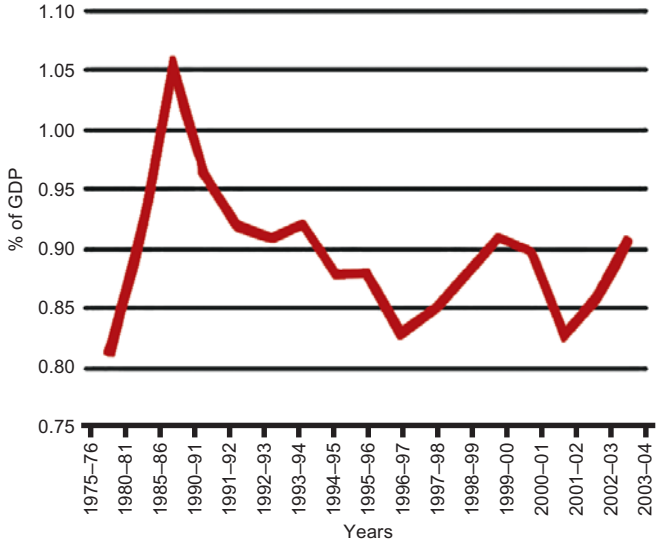

FIG 1. Trends in health expenditure as percentage of GDP (*Source: Report of the National Commission on Macroeconomics and Health*, Ministry of Health and Family Welfare, New Delhi, 2005)

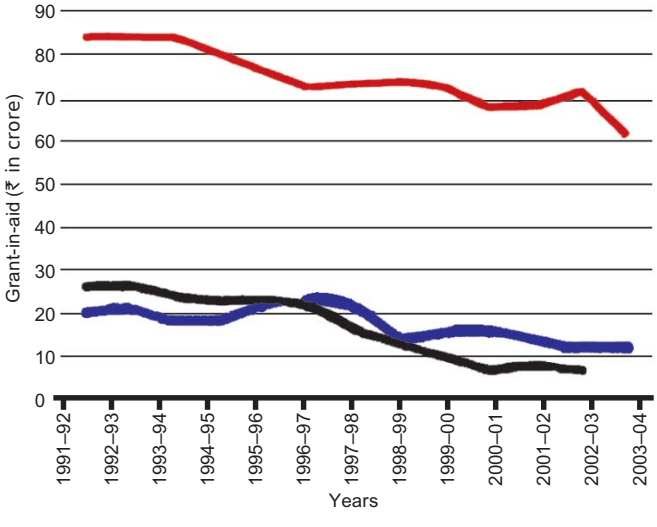

FIG 2. Trends in grant-in-aid allocations by the Ministry of Health and Family Welfare to States and capital expenditure (₹ in crore). (*Source: Report of the National Commission on Macroeconomics and Health*, Ministry of Health and Family Welfare, New Delhi, 2005)

pocket expenditure and 0.2% is the contribution of private employers and employees. Much of this expenditure is incurred on curative healthcare, instead of preventive and promotive healthcare, which would lead to overall health gains for society. A substantial amount of expenditure is made under duress due to illness, by taking loans or selling assets.[18] According to Prabhu and Selvaraju, high private expenditure on health points to the failure of the public sector to provide adequate healthcare services and is a reflection of the relatively high disease burden and high cost of healthcare—not a choice of the people.[3]

The economic crisis of the 1990s followed by the SAP resulted in a slowing down of improvements in health outcomes and a further widening of the rural–urban gap. Public healthcare facilities have been incapacitated because of insufficient inputs, as well as the policies of privatization, including the introduction and/or increase in user charges. The private sector has come to occupy the dominant position in the health infrastructure of India. According to estimates, the total value of the health sector in India today is over ₹1500 billion (US$ 34 billion). Of this, 15% is publicly financed, 4% is from social insurance, 1% from private insurance (Mediclaim policies, 85% to public sector insurance companies) and the remaining 80% from the pockets of patients as user fees (85% of which goes to the private sector).[15] The dominance of the private health sector today is reaffirmed by the following:

1. It is estimated that 85% of doctors (850 000 qualified and over 1 million unqualified) in all systems of medicine are in the private sector.[19]
2. In terms of ownership status of hospitals and hospital beds, in 1996, over 60% of hospitals and 37% of hospital beds were in the private sector.[20]
3. According to the National Sample Survey (52nd round), in 1995–96, the share of the private sector in outpatient care was 82% and in in-patient care, 56%.[21]

Thus, the healthcare policy conceived on the eve of Independence was reversed by the beginning of the 1990s. The private healthcare sector, especially the corporate sector, which was very small at the time of Independence, has come into its own and is influencing the health policy of India, not necessarily in a positive manner. The National Health Policy, 2002 states, 'This policy welcomes the participation of the private sector in all areas of health activities—primary, secondary or tertiary. However … it can reasonably be expected that its contribution would be substantial in the urban primary sector and the tertiary sector, and moderate in the secondary sector.' Even on the subject of healthcare for the poor, it says, 'In the context of the very large number of poor in the country, it would be difficult to conceive of an exclusive Government mechanism to provide health services to this category. It has sometimes been felt that a social health insurance scheme, funded by the Government, and with service delivery through the private sector, would be the appropriate solution.'[22] If it is going to be government-funded, then why not government-provided? Are there motives other than profit? This raises concern that government-funded schemes will amount to an organized laundering of public money to private players.

PUBLIC–PRIVATE PARTNERSHIPS FOR FUNDING HEALTHCARE

Public–private partnership (PPP) is the new-age panacea for India's social sector, which includes health. The 12 March 2004 policy paper on PPP prepared by the 'Fiscal Affairs Department' of the International Monetary Fund, in consultation with the World Bank and the Inter-American Development Bank, states: 'By the late 1990s privatization was losing much of its earlier momentum, yet concerns about infrastructure remained in many countries. It was at this time that PPPs began to emerge significantly as a means of obtaining private sector capital and management expertise for infrastructure investment, both to carry on where privatization had left off and as an alternative where there had been obstacles to privatization.'[23] The paper also mentions that PPPs involve 'arrangements where the private sector supplies infrastructure assets and services that traditionally have been provided by the government'. The world over, PPPs are involved in a wide range of social and economic infrastructure projects, but are used mainly to build and operate hospitals, schools, prisons, roads, bridges and tunnels, light rail networks, air traffic control systems, and water and sanitation plants. There are different formats under which the private sector and the government cooperate to run PPPs, but all these invariably commit sizable public resources directly and indirectly to such projects, with the government retaining little effective control over the projects with a view to ensure their social objectives. The National Health Policy, 2002 prepared the background for encouraging PPPs in the health sector.

The saga of PPPs is still unfolding, but the experience we have had until now can help us gauge what lies in store. In the context of healthcare, the establishment of corporate hospitals with the government providing free land, large tax exemptions and even direct financial assistance in exchange for the provision of free services to a certain percentage of poor patients is one example of PPP. The Apollo Indraprastha Hospital was founded in 1996, in collaboration with the Apollo Hospitals Group and the Government of the National Capital Territory of Delhi, on the lines of a PPP in health. The government leased 12 acres of prime land at a nominal sum of ₹1 per month. At a cost of more than ₹1700 million, the government built the entire hospital building. In addition, the Delhi government is a stakeholder to the extent of 25%. The rest of the money was drawn from public financial institutions, with only a small percentage of the initial investment coming from the Apollo Group. To begin with, the hospital had an in-patient capacity of 600 beds, of which 200 were reserved for poor patients. According to the lease of the hospital (copy available with us), the hospital could allot a maximum of only 5 beds out of the ones reserved for poor patients to the paying patients, only in case of emergencies. Even for this, post-facto permission had to be taken from the government. The lease also made it incumbent upon the hospital to treat poor patients free in the outpatient departments.[24] This has not happened in spite of public interest litigations being filed in courts and the issue being raised in the media from time to time. Having profited from the initial investment by the government, the Apollo Hospital Corporation has now offered to buy up the entire share of the Delhi government.

'Subsequently, a committee appointed by the Delhi government under the chairmanship of a retired High Court judge, Justice A. S. Qureshi, heavily indicted Apollo Hospitals, among many others, for violation of its commitment to treat poor patients free of charge.'[25] Many corporate hospitals have come up since and public money is being spent by governments to ensure private profit at the cost of the poor and preventive healthcare programmes.

Five problems have been identified with private-for-profit provision of health services. These are related to the use of illegitimate or unethical means of maximizing profit, less concern for public health goals, lack of interest in sharing clinical information, creation of brain drain among public sector health staff and lack of regulatory control over their practices.[26] Rosenthal makes similar points about

the involvement of the private sector in delivering public health services.[27] It is thought that not-for-profit non-governmental organizations (NGOs) may be easier to engage as partners. However, many have pointed out the difficulties involved in NGOs working with the government and the financial motives of the NGOs,[28,29] particularly those which are often established by influential people to garner funds from the State.

Among the other issues to be noted while discussing PPPs are the apparent difference between the public and the private sector in terms of resource commitment (long-term commitment by the public sector compared to short-term commitment by the private sector), and the type of patients seeking services. PPPs are being encouraged in National Health Programmes for the control of malaria, tuberculosis, etc. There are a number of examples of existing public infrastructure being handed over to the private sector for management as a joint partnership. These include the handing over of primary health centres to NGOs. A superspecialty hospital in Belgaum was handed over to the Apollo Group. Another example is the financing of the establishment of a cardiac centre on a turnkey basis by the Escorts Group in Chhattisgarh. As part of PPP, there has been contracting out of the profit generating medical treatment facilities, diagnostic services for high-end equipment in West Bengal and drug stores management in Rajasthan.[17] Other forms of contracting are for specific ancillary services such as security, canteens, sanitary services and landscaping.

In many states, the management of public health institutions and medical colleges has been handed over to autonomous registered societies and corporations. Except for the salary of the employees, these corporations and societies have been authorized to generate their own resources. The government is thus distancing itself from its responsibility of providing these services. Government efforts to collaborate with the private sector have been programmatic, sporadic, disjointed and tentative, and not the result of a well-thought strategy aimed at achieving national health goals. Except for the not-for-profit collaborations with NGOs, these experiences have been far from satisfactory.[17]

CONCLUSION

The health indicators of a country are the most sensitive indicators of its socioeconomic development. India continues to suffer from the ignominy of having among the poorest health indicators in the world. Globally, substantial improvements in the area of public health have been possible with governments playing an active and dominant role. India cannot be an exception. The dearth of resources increasingly seems to be an untenable excuse for the government to hold back while considering its involvement in the health of the people. Cuba is an excellent example of a low-cost public healthcare system that is efficient and reflects the resultant health indicators.[30] There is no substitute for adequate government spending on health, which should be considered as a national issue of prime importance in order to make meaningful progress. This needs to be understood by the government and its health policy-makers at the earliest. Healthcare professionals need to play a part in creating the public opinion necessary for this to happen.

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