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Health Financing Coping Behaviour and Socio-Economic Outcomes in India

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ABSTRACT: A recent analysis of constitutional provisions revealed that 68 of the 191 UN countries guaranteed right to medical care services by 2007. India, which officially turned a middle-income country in the same year, was not one among them . India's transition to a middle-income status meant little to most Indians as the spectacular economic growth of the recent past was not reflected in equally glowing terms in improvements in social indicators. If we go by poverty headcount ratio based on $2 a day earnings (PPP) of the World Bank, India had more than 700 million poor people in 2011- more than Europe's total population and about threefourths of Africa's total population. There have indeed been many gains in some human development indicators, but these have often fallen considerably short of the goals we had set for ourselves. India accounts for the highest number of maternal deaths in the world, and together with Nigeria (14%), accounted for one-third of all global maternal deaths. The National Rural Health Mission (NRHM) aimed to reduce the Infant Mortality Rate (IMR) to 28/1000 live births, the Maternal Mortality Rate (MMR) to 100/ 100000 live births and the Total Fertility Rate (TFR) to 2.1 by 2012. With IMR at 40 and MMR at 167 in 2013 , only TFR seems anywhere near the goal set with 24 of the 29 states and 9 UTs achieving replacement levels of fertility . This achievement however is an indication of the focused attention that fertility control has received across the country, often resulting in tragic human rights violations in mass sterilisation camps, targeting the poor . With IMR and MMR still lagging behind, the success of family planning programmes is often at the cost of quality and access improvements in healthcare in general . Of the 1240 million Indians, about 70% still live in rural areas. As a recent review shows, public financing of health is among the lowest in the world at just over 1% of GDP, and out-of-pocket (OOP) spending is very high at around 3% of GDP. Share of OOP in total spending in India is one among the highest in the world. It is seen that expenditure on medicines consists of about three-fourths of total out-of-pocket spending. Financial reasons prevented around a quarter of the population from accessing health services. It was estimated that 35% of hospitalisations caused the respective families to be pushed into poverty. In real terms, it meant health payments pushed 60 million people below the poverty line, per year. To put this into perspective, it is equivalent to the total population of the United Kingdom.

KEYWORDS: health, coping, India, financing, socio-economic, outcomes, behavior, programmes, population

I. INTRODUCTION

The idea of universal healthcare had its origins at the Alma Ata Conference in 1978, where Health for All was agreed upon by all the 134 participant countries. The conference broadly defined health with a strong focus on universal primary healthcare (PHC) and equity. India too is a signatory to the Alma Ata Declaration which affirmed that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.[1,2] The Alma Ata declaration is considered to be an intellectual and moral leap forward for humankind. After three decades which did not see much action in global health in the spirit of Alma Ata, the 2010 World Health Report popularised the concept of Universal Health Coverage (UHC) across global policymakers. With a focus on financial protection, UHC is described by World Health Organisation (WHO) as "access to good quality health services without people experiencing financial hardship because they must pay for care".. Since the publication of the 2010 World Health Report, UHC has achieved momentum, and countries across the world have made time-bound commitments to achieve it. WHO's Discussion Paper on Positioning Health in the Post-2015 Development Agenda called UHC "a practical expression of the concern for health equity and the right to health".

Sengupta (2013) observes that one reason for the unified support of UHC among international agencies was the global rise in catastrophic OOP spending on healthcare, in the backdrop of crumbling public health systems, which in turn was a consequence of a prolonged period of neglect of public healthcare and privatisation of health systems, as prescribed by the Structural Adjustment Programme (SAP) in the 1980s. Because of the devastating effects of such health shocks, OOP spending became politically untenable and UHC was seen as a solution. In a way, for many international

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institutions like the World Bank and experts like David de Ferranti, the promotion of UHC often meant a reversal of some of their previously held policy positions. In an interview just before its biannual meeting in 2014, the World Bank head Jim Yong Kim admitted: "There's now just overwhelming evidence that those user fees actually worsened health outcomes. There's no question about it. So did the bank get it wrong before? Yeah. I think the bank was ideological". This echoed words of WHO head, Margaret Chan from five years ago: "User fees for health care were put forward as a way to recover costs and discourage the excessive use of health services and the over-consumption of care. This did not happen. Instead, user fees punished the poor". [3,4]

Yates and Dhillon (2014) observe that the recent Lancet Commission on Investing in Health focused on public financing mechanisms and redistributive risk pools in reaching UHC and explicitly rejected the 1993 World Development Report's (WDR) emphasis on private financing including user fees and it marks a new consensus. United Nations Sustainable Development Solutions Network (UNSDSN) in 2014 proposed a set of financing targets for the member countries: public healthcare expenditure should be 3% of GDP in low income countries; 3.5% of GDP in lower middle income countries; 4% of GDP in upper middle income countries and 5% of GDP in high income countries. WHO, on the other hand, gave more specific suggestions and recommended four key priority actions to finance UHC: reduce direct payments, maximise mandatory prepayment, establish large risk pools, and use general government revenue to cover those who cannot afford to contribute. UHC implies that everyone receives access to essential healthcare and do not suffer major financial adversities when seeking health services. The word "universal" in UHC could refer to the total coverage of population needing healthcare, or to the comprehensiveness of health services that are provided, or both. However, India has moderate ambitions when it comes to UHC, and the[5,6] Twelfth Five Year Plan envisaged an increase in public health spending to about 2.1% of GDP by the end of 2017. If achieved, it would still mean a doubling of the current spending level as these are nowhere near the 3.5% as suggested by UNSDSN.[24]

Furthermore, there have been criticisms that the push and the urgency for UHC is being utilised to rationalise a partnership between public and private sectors with an emphasis on tertiary care. India's non-seriousness when it comes to universal access is also reflected in the fact that public healthcare delivery system still has user charges, despite such charges being established globally as a serious access barrier and rejected as already seen. Despite familiar arguments regarding lack of resources to be spent on social sectors, and the aggressive expenditure compression policies followed by the government to meet fiscal deficit targets, there indeed are alternative sources that can be and will have to be tapped in order to generate more resources for health, as discussed in a later section. [7,8]Moreover, the big question seems to be how these new funds will be spent—whether through an expansion of the existing public healthcare delivery system or using an insurance-based, private sector dependant platform to expand services, or a cautious combination of the two? An earlier Oxfam India publication had observed that in a context where accountability is weak, demand side financing needs to be used cautiously as they risk moving attention away from the more meaningful task of strengthening public delivery across the country.[23]

II. DISCUSSION

Over the past few decades, India has made significant gains in health outcomes. The IMR was 134 per thousand live births at the time of Independence and has declined to around 40 in 2013. MMR has improved from 560 per 100000 live births in 1990 to 167 in 2013. The Crude Birth Rate (CBR), reflecting the huge mortality load, stood at 39.9 in 1941-51, declining to 21.4 in 2013. The Crude Death Rate (CDR) declined from 27.4 in 1941-51 to 7.0 in 2013. As a consequence, life expectancy, which was around thirty at the time of independence, is now in the mid-sixties. Nevertheless, India's achievements on this front have not been comparable to its economic gains and it has worse health indices than most developing countries in the world. [22]

Health achievements in India have been extremely modest when compared to most other developing countries, and that outcomes are linked with level of public health spending. India's first Health Policy that was adopted in 1983 set out to provide "universal, comprehensive primary health care services, relevant to the actual needs and priorities of the community". This notwithstanding, India has one of the lowest public health expenditures in the world, and a high proportion of private spending. It is therefore not surprising that we have among the world's highest proportions of undernourished children and women, one of the highest rates of maternal mortality in the world, and an extremely high load of preventable and communicable diseases. Overall health spending accounts for 4.1% of India's GDP which amounts to very low per capita health spending, and in terms of absolute numbers, this is fairly average for a lower to middle-income country. The negative effect of overall low health spending is aggravated by low levels of public spending on health. Taking into account the profound weaknesses of the healthcare system, especially in rural areas, the central government initiated NRHM in 2005 to strengthen India's rural public health infrastructure,[9] with special reference to poor performing states

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In spite of the stated objective of raising the outlays for public health from 0.9 % to 3 % of GDP by 2012 through NRHM and expanding public health infrastructure substantially, we find that public health spending remains just above 1 % of GDP. According to the Bulletin on Rural Health Statistics in India (2014), there is a shortage of 36346 Sub Centres, 6700 Primary Health Centres (PHCs) and 2350 Community Health Centres (CHCs) in India. In addition, crippling shortage of human resources at all levels of public healthcare delivery system has a negative multiplier effect on the quality of care. Despite less than expected improvements in health infrastructure and personnel, there have been improvements in indicators like immunisation, institutional deliveries and antenatal care. 34 A study looking at health budgets found that despite the adoption of NRHM, public expenditure on health increased only marginally to 1.2 % of GDP in 2009-2010. This resulted in continuing poor quality of preventative care and poor health status of the population and forced people to seek private care, resulting in very high out of pocket spending. [21]

A study looking at state level experiences found that on an average the distribution of expenditure between secondary and tertiary healthcare system in India does not seem to follow the desired pyramidal structure of expenditure. In other words, the share of expenditure in tertiary healthcare facilities tends to be much higher than secondary healthcare facilities. Indian health system is plagued with serious problems such as sharp inequalities in health outcomes, deficient coverage, unequal access, poor quality and high costs, which have been explored in a study supported by Oxfam India. These serious deficiencies are not accidental. They have been primarily caused by the patterns of financing for healthcare in India. Per capita public health spending is an extremely significant variable affecting life expectancy at birth across Indian states.[10]

According to calculations by Choudhury and Kumar (2011), the association between per capita Gross State Domestic Product (GSDP) and life expectancy at birth disappears with the inclusion of per capita public health spending. It was noted that factors like the priority assigned to health, equitable provisioning and reach of health services, the quality of healthcare, the institutional milieu in which service delivery takes place and complementary investments in sectors other than health such as basic education, nutrition, sanitation and water became equally important paraeters. The level of per capita public health spending at the state level is also a function of how tax revenues of central as well as state governments are distributed across states. Choudhury (2014) found that public spending on health is particularly low among Indian states with low fiscal capacities. This partly stems from the inability of the Central Government to offset structural fiscal bottlenecks in the states through vertical transfers.[20]

Despite spending a greater share of their total expenditure on health, the level of per capita health spending in these states remains low. The additional requirement of health spending needed in just the six poorly performing states is to the extent of 65%, for a minimum level of healthcare services. Lessening the effectiveness of health spending further, particularly in the low performing states are the gaps in human resources and their skewed distribution. It is well established that high morbidity and mortality rates in the country are mainly due to the alarmingly low public investment in health as discussed earlier. The National Health Policy (NHP) acknowledging this noted that, “public health investment over the years has been comparatively low, and as a percentage of GDP, has declined from 1.3 % in 1990 to 0.9 % in 1999”. Health spending has declined as a proportion of total plan expenditure from 3.3 % in the First Plan to 2.09% in the Tenth Plan while expenditure on Family Welfare increased as a proportion of total plan expenditure from 0.1% to 1.83% during the same period reflecting the priorities of the government.

III. RESULTS

Deolikar et al (2008) observed that public spending on health in India peaked at about 1.6 % of GDP and 4 % of the government budget in the mid 1980s. During the 1990s, government health spending failed to keep up with the expanding economy, and, by 2001, it constituted 0.9 % of GDP and 2.7 % of the government budget. These numbers fell to 0.8% and 2.4%, respectively, by 2005. However, from the 2006–07 budget, this trend slowly reversed with increased allocations witnessed in social sectors. Investments in health have started receiving a higher priority primarily because of the perceived role of health of the working population in accelerating and sustaining economic growth and, to a lesser extent, because of the growing recognition of health as a human right. [19]

Across urban and rural areas, most deliveries are now taking place in government hospitals (SRS 2013). Given that there are schemes across the country that offer incentives deliveries in private sector facilities, this is a remarkable result. However, the reported cuts in social spending by the central government to meet the fiscal deficit targets will surely offset the gains made in the recent years. Sharp expenditure compression policies are in place and the revised health sector plan expenditure is reported to be Rs.7,000 crore lower than the budgeted amount for 2014-15.

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After the rolling out of NRHM, the per capita public expenditure on health has been increasing, although at a slow rate. This increase was visible across the states and studies have shown that the relative share of public expenditure on health by centre and states has remained steady at around 40: 60 in the period 2004- 05 to 2010-11. Reflecting the high growth rate, an aggregate share of health spending which increased by 0.2 % of GDP meant that, in per capita terms, there has been a sharp rise in per capita public spending on health in the same period. In 2004-05 prices, per capita public expenditure on health in the country nearly doubled in the period from about Rs. 263 in 2004-05 to Rs. 486 in 2010-11.[18]

The National Common Minimum Programme (NCMP) in 2005 had made a commitment –and the government made an announcement later - to increase public spending on health to 2.5-3 % of GDP over 5-7 years. The 3% of GDP target was endorsed by almost all relevant government policy documents on health; be it the report of the Working Group on Health Care Financing including Health Insurance for the Eleventh Five Year Plan (2006), the Approach Paper to the Eleventh Five Year Plan (2006), the Eleventh Five Year Plan document (2007–12), the report of the High Level Expert Group (HLEG) of the Planning Commission on Universal Care (2011), or the report of the Steering Committee on Health for the Twelfth Five Year Plan. The Twelfth Five Year Plan document, however, scaled it down to a moderate target of only 2.1% of GDP by the end of the plan period, i.e. by 2017. To achieve public spending of 3% of GDP, calculations reveal that the nominal per capita health expenditures will have to go up from Rs 267 in 2005–06 to Rs 2,430 by the target year. At the current rate of spending, it is clear that such an eventuality is highly unlikely in the near future.[11]

In this context, the National Advisory Council (NAC) Working Group on UHC in 2013 found that for most states in India, it would not be possible to offer UHC given the current levels of financing - no matter who the provider is, whether it be public or private sector, and what method of purchasing it may be, whether supply side or demand side. Given this policy background, it is puzzling that academics reportedly close to the current political dispensation give policy advice that flies in the face of existing evidence, including what was compiled and presented by the HLEG on UHC

Given the political patronage enjoyed by the private healthcare industry, and since the government is already experimenting with incorporating outpatient care in the existing Rashtriya Swasthya Bima Yojana (RSBY) , these recommendations have a high likelihood of gaining policy traction, and can put a serious threat to health equity in the country, by undermining the public healthcare delivery system further. Cross-national research has shown predominantly private health systems to be highly regressive, serving the richest far more than the poorest. Analysis of data from 44 low and middle income countries suggested that higher levels of private sector participation in primary healthcare have been associated with higher levels of exclusion of poor people from treatment and care. At the same time, recent Oxfam research (Seery, 2014) has shown that universal public services are one of the strongest weapons in the fight against inequality. They mitigate the impact of skewed income distribution, and redistribute wealth by putting ‘virtual income’[16,17] into the pockets of the poorest women and men. In India, supporting community empowerment and participation as a tool to ensure accountability in the system and meeting the institutional requirement for the same remains relatively unexplored. Like in the case of Accredited Social Health Activists (ASHA), community based efforts are often designed to be driven solely by voluntarism, even as the expectations in terms of outcomes are quite high. The assumption seems to be that community empowerment and participation will happen with minimal effort or financial commitments. Focused and adequate financial commitments for community based accountability measures and decentralised planning will be a step forward in the right direction.

While India’s efforts to expand healthcare access have historically focused on supply-side interventions, in the last decade, there have been various interventions focusing on demand-side policies which engaged the private sector in a plethora of ways. At the national level, the first of such schemes was Janani Suraksha Yojana (JSY) launched in 2005, which provided incentives for institutional deliveries at health facilities, public and private. In 2006, the government of Gujarat launched the Chiranjeevi Yojana , which engaged the private sector facilities for institutional deliveries, since public hospitals were seen to lack the capacity and reach to serve many rural areas. [14,15] The rationale for these schemes was to make use of the existing private sector capacity. A shift to promote institutional deliveries as opposed to safe deliveries -whether at home or at a facility- has also come along with such demand-side financing schemes. It is interesting to note that in Britain, the latest NHS guidance from National Institute for Health and Care Excellence (NICE) suggests that 45% of births-the low-risk ones - are ‘unsuitable’ for hospitals and recommends that women should have all four possible delivery options available to them: hospital care, midwifery units in hospitals, midwifery units based in the community and at home. Parallel to the moderate efforts through NRHM, a new health insurance system supported and sustained by public funds is being systematically built by the central/state governments. The growth of government health insurance schemes at the national level and across states has brought new opportunities

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for the private sector. The Rajiv Aarogyasri Scheme of Andhra Pradesh triggered similar schemes in several other states like Tamil Nadu, Karnataka, Maharashtra, and Gujarat. A national insurance scheme named Rashtriya Swasthya Bima Yojana (RSBY) was rolled out in 2008 in a phased manner. It is estimated that by 2015, 50% of India's population will be covered by government insurance schemes.[10]

IV. CONCLUSIONS

Government should be the primary provider of healthcare, and provision of healthcare for all should not be based on expansion of health insurance-based models focusing on hospitalisation. A clear roadmap to enhance budgetary spending on healthcare to 3%-5% of GDP should be drawn. Public tax-based funding and contribution from the organised sector should finance healthcare and focused funding in the form of specific central transfers should be made to promote equitable access.[13] Regulation of the private sector must be a priority. Establishment of standard treatment protocols and empowerment of communities to hold the healthcare system accountable will be critical to ensure quality of healthcare in the public and private sectors. A comprehensive review of RSBY and other currently fragmented government funded healthcare schemes should be conducted with the aim of future consolidation for a national programme ensuring healthcare for all.[12]

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