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FINANCING HEALTHCARE FOR ALL IN INDIA: TOWARDS A COMMON GOAL

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ACRONYMS

ASHA	Accredited Social Health Activist
BPL	Below Poverty Line
CBR	Crude Birth Rate
CDR	Crude Death Rate
CGHS	Central Government Health Scheme
CHC	Community Health Centre
ESIS	Employee State Insurance Scheme
GDP	Gross Domestic Product
GSDP	Gross State Domestic Product
HLEG	High Level Expert Group
ICICI	Industrial Credit and Investment Corporation of India
IFC	International Finance Corporation
ILO	International Labour Organisation
IMR	Infant Mortality Rate
IRDA	Insurance Regulatory and Development Authority
JSY	Janani Suraksha Yojana
MMR	Maternal Mortality Rate
MNC	Multi National Corporation
NAC	National Advisory Council
NCMP	National Common Minimum Programme
NEP	Net Earned Premium
NFSA	National Food Security Act
NHAM	National Health Assurance Mission
NIC	National Insurance Company
NICE	National Institute for Health and Care Excellence
NRHM	National Rural Health Mission
OOP	Out-of-Pocket
PHC	Primary Health Centre
PHFI	Public Health Foundation of India
PPP	Public Private Partnership
RSBY	Rashtriya Swasthya Bima Yojana
SAP	Structural Adjustment Programme
TFR	Total Fertility Rate
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNSDSN	United Nations Sustainable Development Solutions Network
WDR	World Development Report
WHO	World Health Organisation

ABSTRACT

India continues to have among the lowest public health budgets in the world at just over 1% of Gross Domestic Product (GDP) and it gets reflected in the performance of the public healthcare delivery system – be it in the form of user charges acting as a major access barrier, decaying infrastructure, severe staff shortages or unavailability of medicines. The public and the private sector remain notoriously unaccountable. Despite the country's newfound middle-income status, the ineffectiveness of the Indian health system and characteristically high health-related out-of-pocket hospital payments have pushed around 60 million people below poverty line; the number is equivalent to the population of the United Kingdom.

Increased spending through National Rural Health Mission (NRHM) and the focused attention to rural healthcare are slowly yielding results. In a major shift from 2004 when only one-fifth of the total outpatient care and 40 % of in-patient care by the public sector, most deliveries across urban and rural areas are now taking place in government hospitals as pointed to by data from 2013 Sample Registration System (SRS). Given that there are schemes across the country that offer incentives deliveries in private sector facilities, this is a remarkable result. In this context, aggressive expenditure compression policies followed by the current government to meet fiscal deficit targets are a major cause of worry. Familiar arguments regarding lack of resources for social sectors notwithstanding, there indeed are alternative sources that can be, and will have to be, tapped in order to generate more resources for health. Moreover, the big question seems to be how these new alternative funds will be spent— will it be through an expansion of the existing public healthcare delivery system, or an insurance-based, private sector dependant platform, or through a cautious combination of the two?

This paper explores available evidence and tries to contextualise and map the debate. While the focus of this paper is on healthcare in response to current policy debates, Oxfam India recognises the crucial importance of adopting a holistic approach to health, addressing factors such as nutrition and sanitation, and broader social determinants of health. In the light of the analysis presented in the following sections, we recommend that:

- 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.
- 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.



CHAPTER 1

BACKGROUND

A recent analysis of constitutional provisions revealed that 68 of the 191 UN countries guaranteed right to medical care services by 2007.¹ India, which officially turned a middle-income country in the same year, was not one among them². 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 three-fourths of Africa's total population.³ 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.⁴ 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 2013⁵, only TFR seems anywhere near the goal set with 24 of the 29 states and 9 UTs achieving replacement levels of fertility⁶. 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 poor⁷. 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 general⁸.

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.⁹ 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.¹⁰ To put this into perspective, it is equivalent to the total population of the United Kingdom.

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 134¹¹ 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.¹² The Alma Ata declaration is considered to be an intellectual and moral leap forward for humankind.¹³

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”¹⁴. 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.¹⁵ 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”.¹⁶

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.¹⁷ 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 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.¹⁸

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”.¹⁹ 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”.²⁰

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.²¹

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.²² WHO, on the other hand, gave more specific suggestions and recommended four key priority actions to finance UHC: reduce direct payments, maximise mandatory pre-payment, establish large risk pools, and use general government revenue to cover those who cannot afford to contribute.²³

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 Twelfth Five Year Plan envisaged an increase in public health spending to about 2.1% of GDP by the end of 2017.²⁴ 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.

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 care²⁵. 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. 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.²⁶



CHAPTER 2

HEALTHCARE FINANCING IN INDIA

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 2013.²⁷ 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 2013.²⁸

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. **Table 2.1** compares health indices in India, Thailand, China, Bangladesh, Sri Lanka, Pakistan and Brazil in relation to their public spending on health.

TABLE 2.1: HEALTH INDICES FOR INDIA AND SELECT COUNTRIES

Indicator	India	Thailand	China	Bangladesh	Sri Lanka	Pakistan	Brazil
Infant Mortality Rate	50	12	17	41	13	70	17
Under 5 mortality Rate	66	13	19	52	16	87	21
Fully immunised (%)	66	98	95	89	99	80	99
Birth by skilled attendants (%)	47	99	96	18	97	39	98
Per capita government expenditure on health (PPP Int \$)	39	247	203	14	66	20	483

Source: HLEG Report 2011 and World Health Statistics, WHO 2011.

It becomes clear from **Table 2.1** that 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".²⁹ 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 diseases³⁰.

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.³¹ 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, with special reference to poor performing states.

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.³² 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.³³

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.³⁵

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.³⁶

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 India³⁷. 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.

According to calculations by Choudhury and Kumar (2011), the association between per capita Gross State Domestic Product (GSDP) and life expectancy

ISSUES IN FISCAL FEDERALISM

In the federal fiscal architecture in India, there is a 'vertical imbalance' between the powers of the states and the Centre to raise revenue through taxes and duties in comparison to their expenditure requirements. The powers of revenue mobilization vested with the states are insufficient to help them mobilize resources that would meet their total expenditure requirements. This kind of a vertical imbalance was built into the fiscal architecture of India keeping in mind the need for the Central Government's interventions to address the 'horizontal imbalance', that is, the limited ability of some of the states to mobilize adequate resources from within their state economies in comparison to others. In the fiscal architecture that has evolved in India, a significant amount of financial resources are transferred from the Central Government every year to every state government so as to enable the state governments to meet their expenditure requirements. In fact, for any state, a large part of the state government's total revenues is provided by the Central Government in the form of: a share in tax revenue collected under the Central Government tax system, grants and loans.

Source: Praveen Jha and Subrat Das (2010), *India's Fiscal Policy Space for Investing in Children*, No 4, IHD - UNICEF Working Paper Series, New Delhi.

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 parameters.³⁸

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 transfers³⁹.

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.⁴⁰ 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”.⁴¹ 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.⁴²

Deollikar 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 2005.⁴³

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.⁴⁴

As shown in **Table 2.2**, 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 2014-15.⁴⁵

TABLE 2.2: PERCENTAGE DISTRIBUTION OF BIRTHS BY TYPE OF MEDICAL ATTENTION AT DELIVERY (2013)

	Total	Rural	Urban
Government Hospital	50.0	48.8	55.0
Private Hospital	24.4	20.9	37.1
Qualified Professional	12.7	14.4	6.1
Untrained Functionary and Others	12.9	15.9	1.7

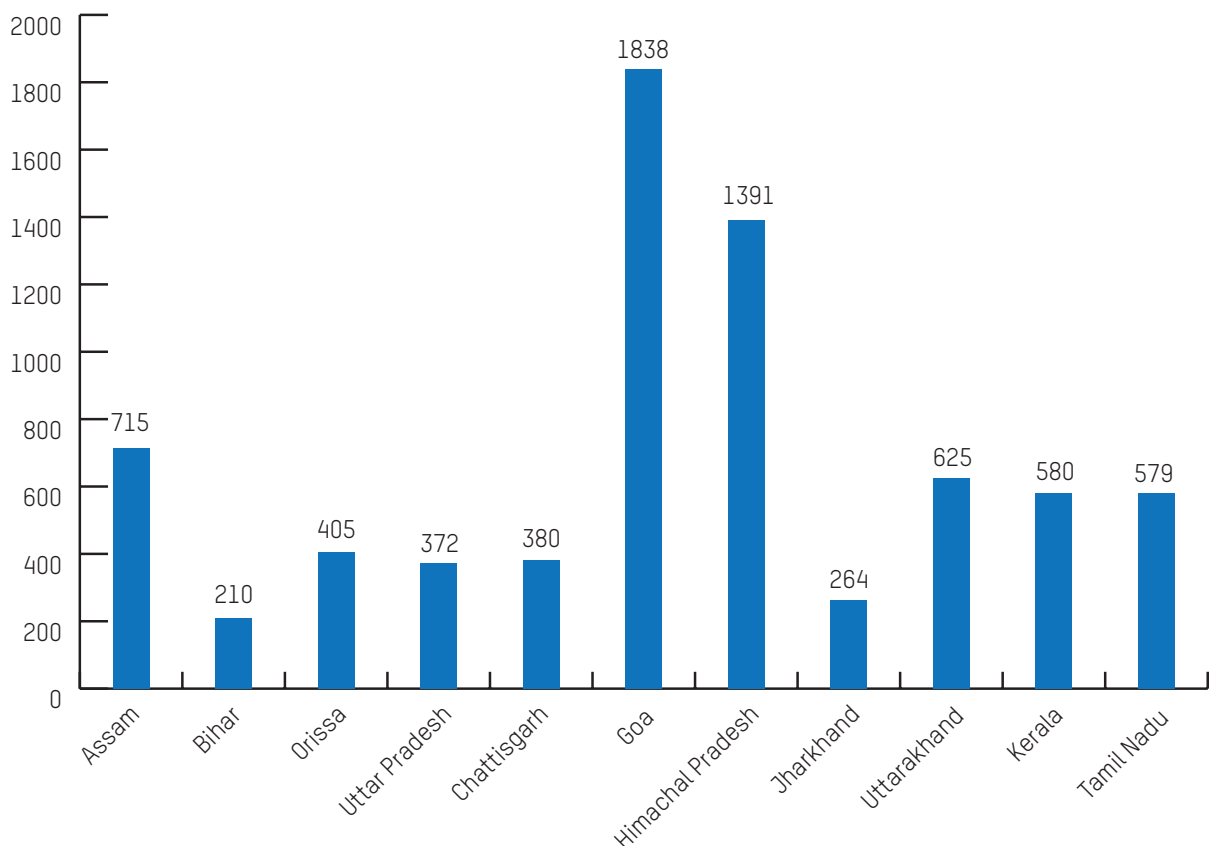
Source: SRS Statistical Report 2013.

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 2010-11.⁴⁶ 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 2010-11.⁴⁷ However, public expenditure at the state level varies significantly, as shown in **Figure 2.1**.

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.⁴⁸ 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.⁴⁹ At the current rate of spending, it is clear that such an eventuality is highly unlikely in the near future.

FIGURE 2.1: PER CAPITA TOTAL PUBLIC EXPENDITURE ON HEALTH IN INDIAN STATES 2009-10



Source: Mita Choudhury and H.K. Amar Nath (2012).

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.⁵⁰

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. In their latest book, the release of which coincided with the change in the central government, Arvind Panagariya and others suggest the following:

*Turning to medical service delivery, we recommend that rather than further expand the provision of free primary, secondary, and tertiary health care services in the public sector, the government must focus on providing financial resources to the poor for routine and non-routine care... **Even so, if the government must insist on the provision of the services, it must do so on the full cost recovery basis.** Once the poor have been provided the financial resources necessary to pay for their health care expenditures, there does not remain a case for additionally free provision of the service by the government.... We estimate that assuming four members per household, the budgetary cost of transferring 2000 rupees per year per household at 2010/11 prices to the bottom half of the population for routine outpatient care would be just 0.38% of the GDP. For an additional 0.38% of the GDP, the government can provide an insurance cover of 40, 000 rupees per household per year at 2010/11 prices for non-routine care in or out of hospital to the bottom half of the population. Thus, excluding administrative costs, the government can provide at least a modest health care cover for the bottom half of the population for just three-quarters of a percent of the GDP. (Panagariya, Arvind et al 2014, emphasis added.)⁵¹*

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)⁵², 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.⁵³ 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' into the pockets of the poorest women and men.⁵⁴

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 commitments⁵⁵. Focused and adequate financial commitments for community based accountability measures and decentralised planning will be a step forward in the right direction.



CHAPTER 3

GOVERNMENT FINANCED INSURANCE SCHEMES IN INDIA

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.⁵⁶

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.⁵⁷

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 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.⁵⁸ The main objective of these new government funded health insurance schemes was to offer protection to below poverty line households against health shocks, defined in terms of an

inpatient stay.⁵⁹ Many of these new schemes are modeled in part on various community-based insurance schemes that have been operating across the country, although at a smaller scale like *VimoSewa*, *Karuna* or *Yeshasvini*⁶⁰.

Although the coverage per se has been quite wide, the *depth* of coverage- which denotes the extent of benefit packages offered in the scheme - has been a mixed bag. A review of existing health insurance models in India conducted by the Public Health Foundation of India (PHFI) showed that the new schemes provide only hospitalisation cover to the beneficiaries. RSBY's package in particular, at Rs 30,000 per family is very modest given today's health needs and costs.⁶¹

The review by PHFI also concluded that privately provided tertiary care, which is expensive and high-margin, can lead to medicalisation of health triggering unsustainable cost-escalation. Taking into account long-term fiscal sustainability, strengthening public healthcare delivery system seems to be a better option.⁶² In the interim period, however, structural constraints may lead to contracting in tertiary care services from the private sector. A strong regulatory system for quality and price control would be a necessary precondition for any such initiative.⁶³

The existing conditions and arrangements for the market purchase and insurance of healthcare remain suboptimal not only in India but also in many of the other lower middle income countries. However, there are lessons to be learned for India from many of these countries, some of which have decades of experience in reforming health systems to expand access.⁶⁴

Serious incentive incompatibility problems ensure that various stakeholders' interests are not aligned towards an optimal outcome – in other words, vested interests and profit maximisation efforts by powerful and influential players in such arrangements can undermine public health goals. . Reviewing these conditions in India, the NAC Working Group on UHC by the Government of India concluded that existing arrangements perpetuate an inefficient use of scarce financial resources as the tendency in the systems is either to deny use -by insurance companies, or to overuse -induced by the medical practitioners, and misuse by both.⁶⁵

3.1 POLITICAL ECONOMY OF GOVERNMENT SPONSORED INSURANCE SCHEMES

The last decade has been one of accelerated expansion for the voluntary private health insurance industry, with annual growth rates of more than 30 %. This rapid growth of the insurance industry represents the latest phase of private sector expansion in healthcare services in India.⁶⁶ In the last decade, India has also witnessed the roll-out of many insurance schemes both by the central and state governments aiming at utilising existing private sector capacity, and hoping that the purchasing power will act as an incentive for new hospitals to come up in the rural areas.

At the time of independence, private sector accounted for about 8 % of India's healthcare facilities.⁶⁷ Over the years, private healthcare sector has grown tremendously with explicit support of the Indian State. Selvaraj and Karan (2009) note that public sector provision of outpatient healthcare accounted for only one-fifth of the total outpatient care in 2004 as against over one-fourth (26%) in 1987-88 in India. The share of public provisions which used to cater to around 60% of in-patient care in 1987-88, has registered a steep decline to approximately 40% in 2004 as well.⁶⁸

The story of growth of the private health sector in India is also a story of systematic neglect of the public health system over the years. The private sector has been the recipient of direct and indirect subsidies from the State, and of late, the social sector itself has become a lucrative market with guaranteed revenue opportunities for private players.

As is true all over the world, in order to maximise profitability, the private sector shares a complex relationship with the State - the State needs to be pushed back so that new markets are captured/created. At the same time, as the global economic recession clearly demonstrated, the State is also often looked up to by the private sector as an insurance against losses in times of economic crises⁶⁹. Socialisation of losses is a very welcome proposition for the private sector during slowdowns as the recent bail-out packages across the globe have demonstrated.

As social sector spending capacity of the developing country governments goes up, the political pressure from the electorate on the State to change its role from that of a deliberate non-player aiding private sector by its sheer absence to that of an active service provider increases. At the same time, pressure from strong private sector lobbies within and around the government to channelise more subsidies through the private sector also mounts. Various new innovative arrangements are tried out, whereby an optimal arrangement is reached where the State becomes a more active player in the profit making endeavour- much more than a rescuer in times of recession, or a source of occasional subsidies. The State then becomes a source of constant and sure income for the private sector, by choosing to be the dominant financier rather than provider of social sector services like healthcare. The developing world, by the sheer number of poor people, thus becomes a profitable business proposition. The private sector quickly identifies the 'fortune at the bottom of the pyramid' in the form of subsidies to the poor, which the regulator/manager State is all too willing to channelise through the private sector.⁷⁰

At the same time, a slow but steady consensus is being reached in the Indian scenario, which implicitly assumes that private sector participation is a non-negotiable since focused policy attention on the public sector will be inadequate. The general argument framed is that any step forward must allow for a substantial role to the private sector, proportional to its share in terms of hospital care provided to the Indian population. The rationale given, however, vary from the well-meaning argument that the dominant private sector can be tamed and used to achieve public health goals, to the faulty claim that private sector uses public money more efficiently.

More often and not, utilisation figures of NSSO rounds from the late eighties onwards are quoted to say that even the poor prefer private sector for healthcare services. It, however, ignores the fact that this was a period when the public sector was systematically starved of resources and market principles were introduced into the system. It also misses the fact that healthcare is not a private good that people consume with complete information. Health services are often an urgent necessity and people often make decisions not taking fully into account quality, costs or other factors affecting access. Thus, poor people being forced to vote with their feet on the public sector cannot and should not be the only argument for more privatisation and more State subsidies to the private sector.

An interesting aspect of the private sector expansion - other than government subsidies- is the nature of international funds that many major Indian private hospital chains have been able to attract. The World Bank Group's newfound commitment to universal and equitable health coverage and to shared prosperity, while welcome, is often at odds with its investment priorities. In India's case, the International Finance Corporation (IFC) which provides loans and advises private sector has been a major mover in the corporate expansion of the hospital sector.

Recent research by Oxfam (Marriott and Hamer, 2014) has shown that all the members of the World Bank Group are not aligned in its objectives of UHC and equity in health.⁷¹ The Health in Africa initiative of the World Bank Group, which was preceded by the publication of a celebrated report titled *The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives* in 2007, aimed at 'harnessing the potential of the private health sector', which was seen as 'an additional and powerful instrument to progress towards the Millennium Development Goals (MDG). Despite the initiative's commitment on benefitting the underserved population of Africa, Oxfam's analysis showed a failure to analyse how to

reach poor people effectively via the private sector; failure to direct investments for the benefit of poor people; and failure to even measure whether poor people are being reached⁷².

A similar story –although understudied– may be at play in India’s case. Reportedly, Indian private healthcare sector represents more than 30 % of IFC’s global healthcare investment portfolio.⁷³ However, the role of and impact of the recipients of these loans within the health sector– as in the case of Africa– remain questionable and further research is necessary to understand this better.

If we briefly look at the indicative case of Delhi, it throws up some interesting findings. Delhi has a large number of private hospitals, which have received free land and other subsidies from the government to provide free services to poor patients. Over time, these *charitable* hospitals have become purely commercial entities, dishonouring the commitments made to the government. A high level committee assigned by the Government of Delhi headed by Justice Qureshi took a bleak view of the nature of such hospitals that claim to be charitable just to lap up subsidies.

Its final report concluded that “most of the charitable hospitals are no more charitable”, although the founders had intended them to be charitable hospitals, providing considerable relief to the poor, needy and deserving patients. In a scathing indictment, the report by the high level committee says that the successors however have been “selfish, greedy and exploitative” and have converted these charitable hospitals to moneymaking machines.⁷⁴ A recent research report which explored the compliance of such private hospitals in Delhi towards legal commitments to serve the poor noted that:

Apollo is supposed to have 200 beds reserved for EWS (Economically Weaker Sections), but the average number of EWS patients treated annually remains in the range of 15 to 20 patients. Only 3 out of 8 free beds were occupied at Fortis, and 4 out of 10 free beds were occupied at Jessa Ram Hospital. Max Devki Devi Heart Institute in Saket has 18 free beds available for EWS out of which on an average only 3-4 beds are occupied (as informed by the regional manager). The Indian Express reports that for three months before February 2010, when the article was written, not a single EWS patient was treated at Rockland Hospital. (SAMA, 2011)⁷⁵

Interestingly, four out of five hospitals– Apollo, Fortis, Max and Rockland – mentioned in the preceding passage as flouters of legal requirements towards healthcare access to the poor, figure prominently on the IFC web portal as recipients of huge loans from the World Bank Group. The limited investment information available on the IFC website indicates that these four hospitals put together have received around \$320 million (around Rs 2000 crore at current exchange rates) over the last decade.⁷⁶

India’s health financing landscape is going through an interesting phase where there is a simultaneous push for both supply-side as well as demand-side interventions using public money. The pursuit of these two routes to UHC, one by strengthening the public health system and another, by government financed insurance has largely been independent of each other with little integration so far between the two.

Rao (2013) notes that this has led to many issues: firstly, the presence of government insurance schemes has made public sector hospitals and private hospitals unequal competitors for funds. While this is viewed as an opportunity for government owned hospitals to gather additional resources, in reality, the situation favours the private sector because of the current status of the historically fund-starved public sector.⁷⁷ However, in some states like Kerala and Chhattisgarh where participation of government hospitals in schemes like RSBY was actively promoted and often mandated by the state government, it has indeed helped.

Rao (2013) also observes that in the current scenario there will be limited fiscal space in the health sector to pursue both routes simultaneously as these will independently require substantial resources. Rejuvenating the public health system can be realised with up to 3% GDP according to the HLEG report.

Another recent estimate suggests that government insurance schemes are expected to consume around 0.8% of GDP and this is expected to grow as coverage increases and the population grows older. In Andhra Pradesh, the *Rajiv Arogyasri Scheme* consumes a substantial percentage of the state's health budget, severely restricting the fiscal space available for primary or secondary level interventions.⁷⁸ Most of the money was absorbed by the private sector.

A recent review of the (Sengupta, 2013) health sector showed that for the *Arogyasri Scheme*, the total payments to facilities accredited from 2007 to 2013 amounted to Rs 47.23 billion, of which Rs 10.71 billion was paid to public facilities and Rs 36.52 billion went to private facilities. It was shown that the scheme drew 25% of the state's health budget while covering only 2% of the burden of disease.⁷⁹

Historically, the incurred claims ratio of health insurance schemes has been way above 100% in India. This has been true for community based insurance schemes- which were a precursor to the current crop of government funded health insurance schemes. Understandably, public sector insurance companies had higher incurred claims ratio vis-a-vis private sector insurance companies. Many public sector companies treated smaller community based health insurance programmes as part of their social responsibility initiative and rejection rates were kept low.

For example, for the community based health insurance scheme run by *Karuna Trust* which focused on socially marginalised people, National Insurance Company (NIC), a public sector company accepted a claim ratio of up to 150% because of the social nature of the scheme.⁸⁰ It was observed that for the company, the insurance scheme was not only a social obligation imposed by insurance regulations, but "a matter of heart". The premiums were artificially kept low as well. It was seen that the company's commercial activities will cross- subsidise the insurance scheme for the poor, and a high incurred claims ratio of such schemes was seen as a symbol of the company's recognition of the 'social character of the scheme'.⁸¹

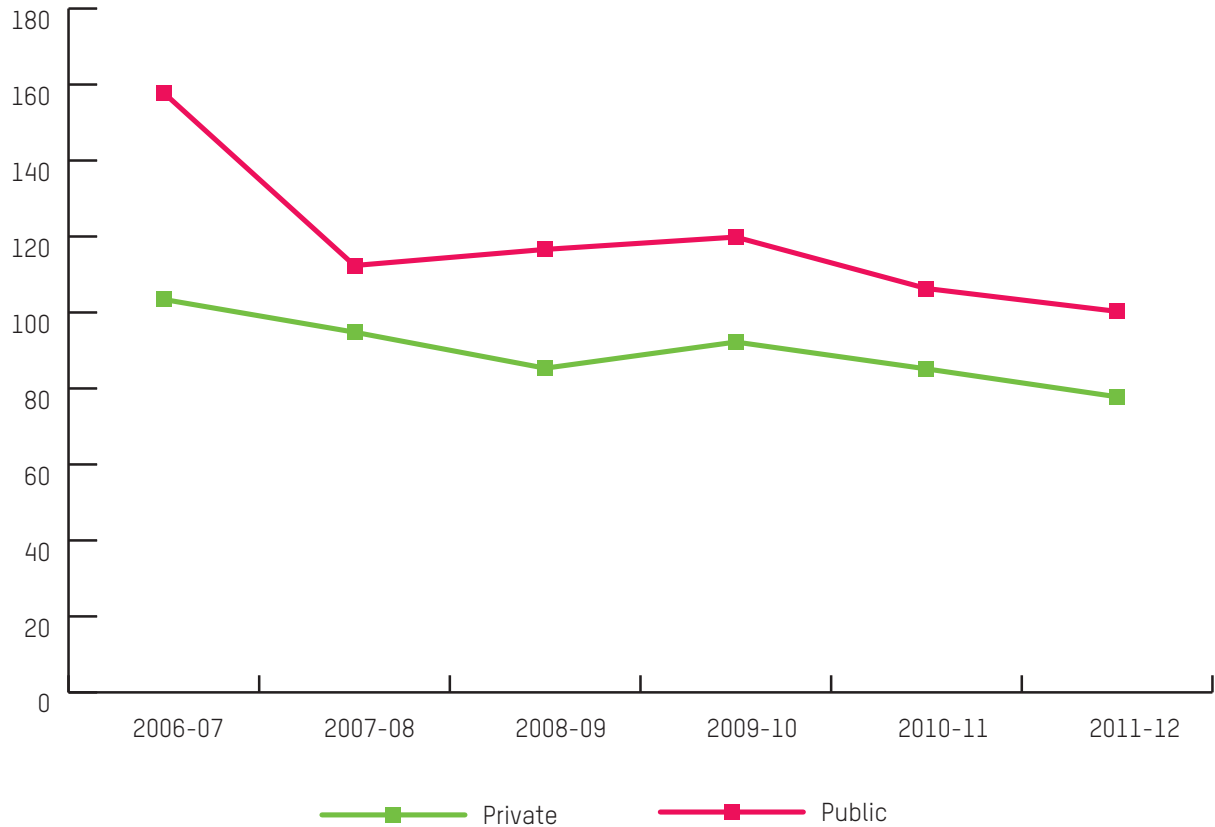
The new crop of government financed insurance schemes for the poor were quite different from the existing ones like Employee State Insurance Scheme (ESIS) and Central Government Health Scheme (CGHS) which focused on employees in the formal sector. The new schemes tied with insurance companies –both public and private- in order to tap into the existing private sector healthcare delivery system.

There are different schemes started by the central government as well as some state governments. There are states where more than one scheme run parallel. There is a widespread perception that public sector does not have the money to expand at the rate at which healthcare needs to expand. Hence, parallel to the expansion of insurance for the poor, the encouragement given to the private sector like concessional land and tax exemptions continue as part of policy.

According to a recent review, all of the newer schemes have a common feature: the use of commercial insurers or Third Party Administrators for underwriting and administrative functions such as beneficiary enrolment, hospital empanelment and claims processing and payment. Most of the managerial functions are thus outsourced given that a robust governance architecture has not yet developed.⁸²

In recent years, the health insurance business with a view to expand their market has been actively encouraging Public Private Partnerships (PPP), with support from the government, whereby private sector gets access to public resources under government mandated health insurance schemes for the poor. The government sponsored health insurance market has boomed in the last few years taking the insured population coverage from 5% in 2008-09 to a whopping 22% in 2010-11. This is a huge bonanza for the health insurance business with premiums under government schemes totalling Rs. 1699.61 crore (of which Rs. 1201 crore was private sector insurance companies) in 2010-11 covering 189 million individuals, up from Rs. 1077.18 crore (of which private sector share was Rs. 887 crore) and a coverage of 167 million in 2009-10. The private banking companies which deal big in government schemes like the Industrial Credit and

FIGURE 3.1: INCURRED CLAIMS RATIO: HEALTH INSURANCE INDUSTRY



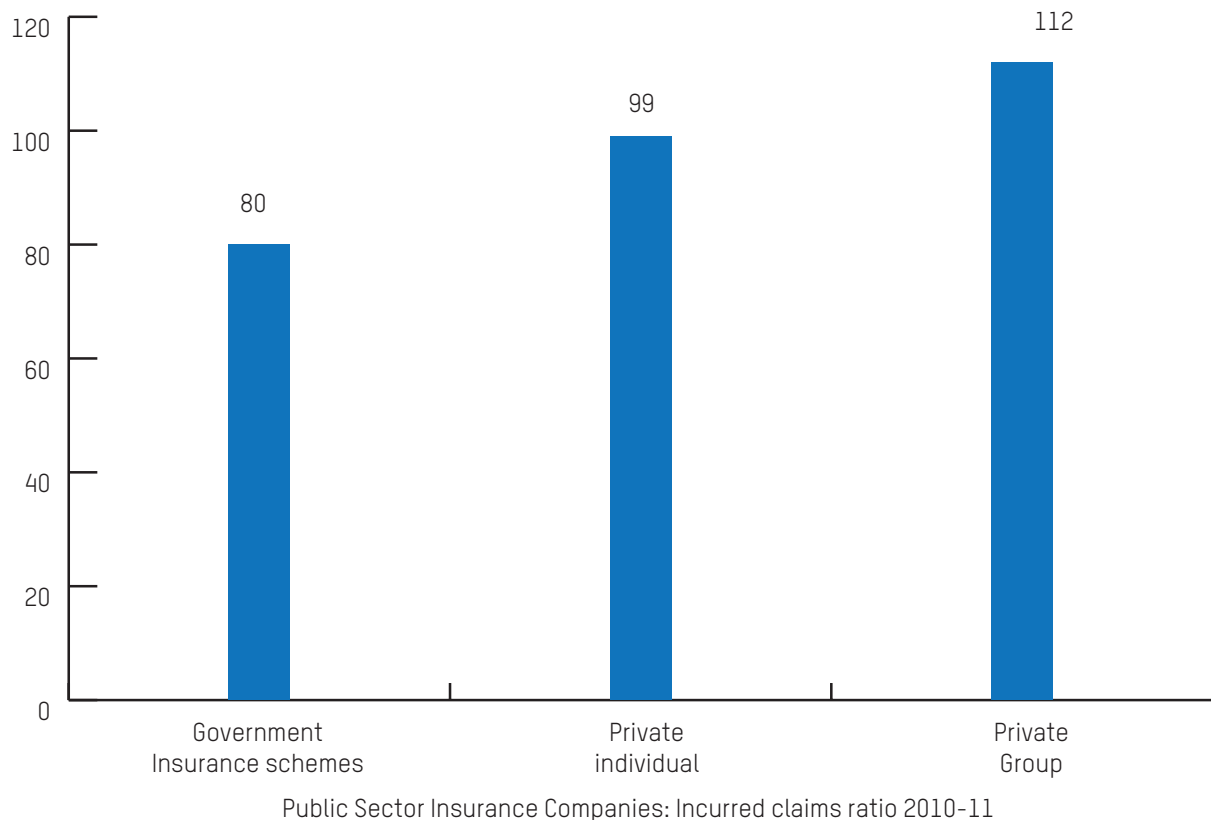
Source: IRDA Annual Reports, various years.

Investment Corporation of India (ICICI), have more than half of their overall business in non-life insurance in government –sponsored insurance focusing on the poor⁸³.

The development of the health insurance market, aided in no small measure by direct government support, has seen many interesting policy developments. As **Figure 3.1** shows, there were efforts to bring down the overall incurred claims ratio of the industry. However, along with the expansion of “government insurance schemes” focusing on the poor in the overall insurance pie, a key reversal of the claims ratios happened whereby private voluntary insurance—mostly covering individuals and organised sector—retained the over 100% status of high claim/low rejection rates, and at the same time saw drastic suppression in the claims ratios of government funded schemes, mostly targeted at the BPL population. As **Figure 3.2** shows, public sector insurance companies which historically had high claims ratios in health insurance schemes focusing on the poor, now have considerably low claims ratios vis-a-vis the private variants of insurance.

This was not something that was driven solely by the profit maximisation objective of the companies. Strong disincentives were put in place by the Insurance Regulatory and Development Authority (IRDA) –the apex body which regulates and develops the insurance industry in India— within the governance structure of the public funded insurance schemes to suppress demand. These strong disincentives worked to suppress claims ratios of public insurance companies in the government insurance scheme sector, as the ratios for the private sector were in any case lower. A circular by IRDA in February 2011 read: “If (..) incurred claims ratio for the said portfolio turns out to be more than 70% for the consecutive four half years, the insurer may not be allowed to participate in the tender for any Government sponsored scheme for a period of at least two years”⁸⁴.

FIGURE 3.2: INCURRED CLAIMS RATIO ACROSS INSURANCE CATEGORIES: PUBLIC COMPANIES



Source: IRDA (2011) Annual Report 2010-11.

However, this was done only for the government funded insurance schemes which ironically targeted the poor, while voluntary private health insurance remained untouched. Such steps did have a negative impact on the historically high claims ratios of public sector insurance companies as well. IRDA data indicates that for the year 2010-11, within the insurance industry, insurance schemes meant for the poor were cross-subsidising the schemes meant for the rich (Figure 3.2).

In real terms, it meant that for the private market meant for the affluent, competition—among other things—kept the claims ratio high, while for the government insurance schemes meant for the poor, regulation kept the claims ratio or the healthcare per rupee spent low.⁸⁵ Supply side moral hazard has emerged as a major issue in government financed insurance schemes involving private players. A recent review covering Maharashtra (Ghosh 2014) found that the total amount of claims in RSBY never crossed 57% ever in Maharashtra. In fact, on an average, the claim ratio was just about 42% in the last five years.⁸⁶

Limiting claims is seen as a policy objective so much so that a new proposed state health insurance scheme calls the surplus created in the system by low utilisation of care by poor patients as “profit”. Understandably, this particular government health insurance scheme has a “profit sharing” clause. It is said: “The scheme also plans to include a clause for “profit sharing” by insurers in the event of a low claims ratio. If the claims ratio falls below a set level, the insurer will be required to give back part of the premium paid for the insurance”⁸⁷. The BJP-led government plans an insurance-led expansion of Universal Health Coverage through the National Health Assurance Mission (NHAM) following the much celebrated PPP model of RSBY that depends on the private insurers and private hospitals in a major way.⁸⁸

Interestingly, data for the year 2010-11 on insurance based Government Health schemes published by IRDA shows that the Net Earned Premium (NEP) collected by all the four public sector insurers put together is lesser than the NEP of the largest private player –and there are seventeen private insurance companies in total. Similarly, RSBY data showed that in Maharashtra, where the quantum of empanelment of private healthcare providers for the scheme was one of the highest, the proportion of public hospitals empanelled for the scheme was less than 1 %, despite having a fairly well-developed public sector as well.⁸⁹

There are calls to exercise caution, as skewed priorities end up distorting the entire structure of the health system and public money is channelised to strengthen the already dominant corporate health sector.⁹⁰ Ideally, health systems should have a pyramid like structure: with a referral system stretching from primary level care to specialised care in tertiary hospitals. Better facilities and quality of care at the base would ensure that fewer numbers would require expensive specialty hospitals to treat serious ailments. It is seen that the health insurance system in India inverts this pyramid and drives public funds away from primary care facilities.

Sengupta (2013) observes that in 2009-2010, direct government expenditure on tertiary care was slightly over 20% of total health expenditure but if one adds spending on the insurance schemes that focus entirely on hospital-based care, total public expenditure on tertiary care would be closer to 37%. Taking an indicative case of Andhra Pradesh, following the implementation of the *Arogyasri Scheme* the proportion of funds allocated for primary care fell by 14%.⁹¹

CHAPTER 4

THE CASE OF *RASHTRIYA SWASTHYA BIMA YOJANA (RSBY)*

RSBY which was launched in 2008 was the second national level insurance scheme focusing on demand-side financing of healthcare. RSBY is now India's flagship national health insurance scheme for people living below the poverty line. In insurance based models such as RSBY, the insurance company would ideally like to enrol a large number of eligible families to maximise the premium income and spend as little as possible. The latter will be achieved by gate keeping functions, like permission for surgical procedures, selection of procedures, cutting out unnecessary diagnostics, surgeries and so on. The interest of the healthcare service provider will be to carry out as many surgical procedures and diagnostics as possible to get the maximum amount per patient. The insured family would like to visit the hospital for almost all illnesses for which it could get cashless services. In this context, the scope of unethical and iniquitous practices is high and the need to have a strong regulator- preferably government- is evident.

Notwithstanding its relatively recent origin, a number of studies have tried to measure the scheme's impact on health service use as well as financial outcomes. The available evidence questions the scheme's ability to offer financial protection and reduce OOP spending efficiently. There is a lot of debate also on the various methodological challenges to assessing impact of such schemes.⁹² In the context of the adverse evidence, a recent review argued that it may be premature to dismiss health insurance initiatives based on the existing analysis because these schemes tend to perform better with time, and advised patience.⁹³ However, this call for cautious optimism seems to be quite misplaced.

By mid-2013, 35 million households had been enrolled in RSBY and it is claimed that 50 % of BPL households were enrolled in the 460 districts where RSBY operates.⁹⁴ These figures however hide wide regional and gender disparities in enrolment. The fact that only five people can enrol per household may have given preference to male members of the family. Overestimation of coverage may also have been a problem as data on renewals is not published. Ghana is a case in point here- when only active members were counted - the official coverage was revised down in 2010 from two-thirds to just one-third of the overall population.⁹⁵

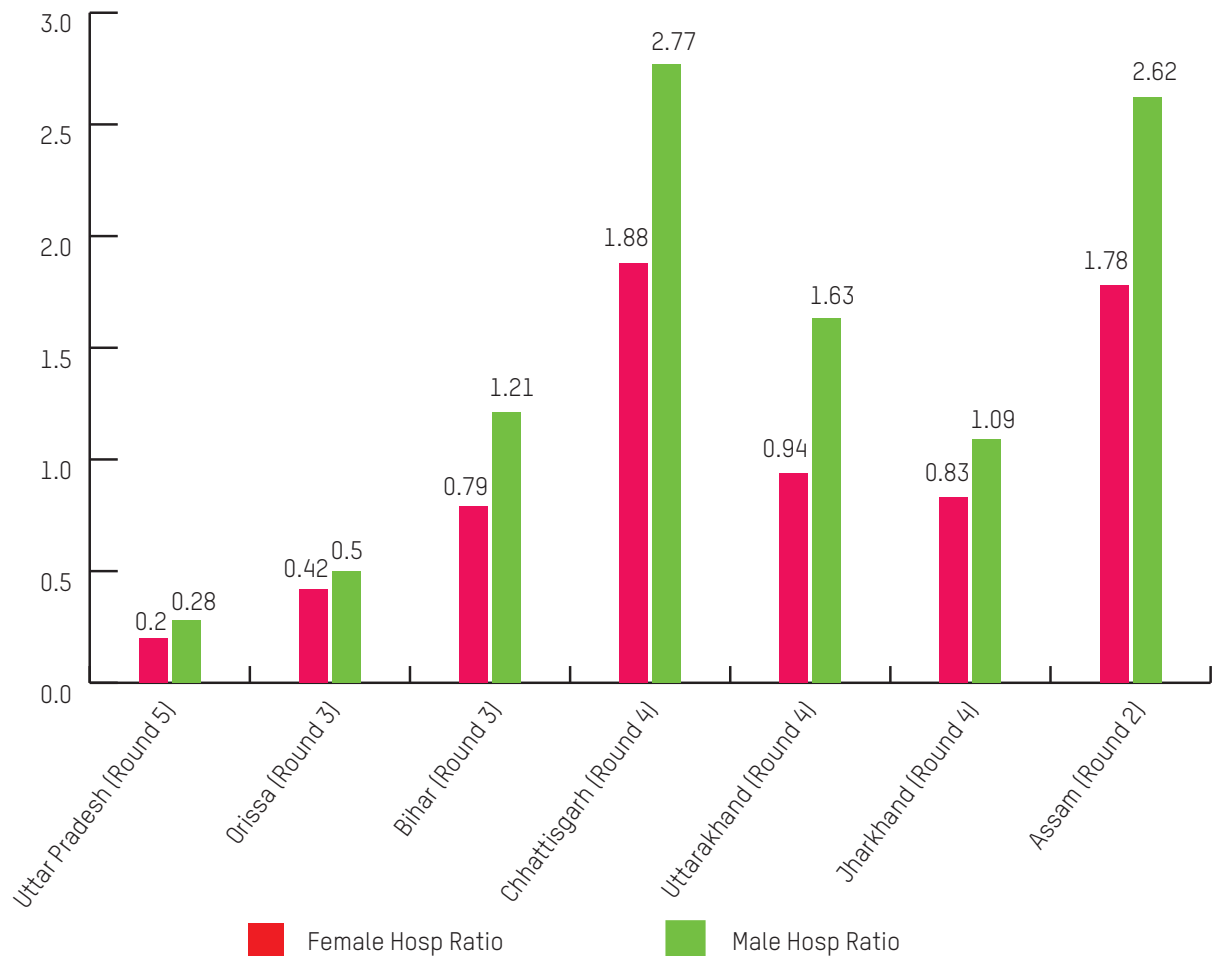
RSBY provides only limited financial protection to the enrolled BPL population with limited secondary level care. It offers Rs.30,000 coverage for a family of five for hospitalisation when three-fourths of OOP health expenditure in India goes towards medicines and hospital visits. As with other similar health insurance

schemes in the states, RSBY tilts public expenditure further away from already fund-starved primary and preventive healthcare.

Cost escalation triggered by increased provider-induced demand is seen as another major issue. The HLEG report warned that the use of independent agents fragments the nature of care being provided, and over time, leads to high healthcare cost inflation and lower levels of wellness.⁹⁶ Even without accounting for cost pressures on the premium in the future, a study (Dror and Vellakkal, 2012) has calculated that the annual cost to the government of India for the premiums of RSBY when all BPL households are enrolled would amount to Rs 24.6 billion by applying the Lakdawala poverty line criterion, or Rs 33.5 billion when applying the Tendulkar poverty line criterion⁹⁷, both very restrictive when compared to the number determined by the latest National Food Security Act (NFSA) as “priority households”. Once the NFSA is rolled out, it just follows that the households that are targeted will be treated as the new BPL. This makes any estimate based on the old or existing BPL criterion a very conservative one. However, cost estimates based on these separate BPL criteria indicate that a complete RSBY coverage will mean about 0.2 and 0.3 % respectively of the total budget.⁹⁸

As revealed in a Karnataka based study, even after six months post-registration, 38 % of households did not have their insurance cards.⁹⁹ In the district of Dangs in Gujarat, several private sector hospitals submitted false claims for several months before being de-empanelled by the insurer but not before the claims ratio for the district exceeded 200 %. In contrast, there are districts where utilisation is unusually

FIGURE 4.1: RSBY HOSPITALISATION RATIOS ACROSS OXFAM’S FOCUS STATES



Source: <http://www.rsby.gov.in> accessed on May 22nd 2014.

low and where insurers, in turn, reap their share of high profits.¹⁰⁰ More serious claims of fraud include the alleged enrolment of thousands of ‘ghost’ beneficiaries by ICICI Lombard — India’s largest private sector insurance company. The losses to government, though not yet fully calculated, are believed to run into tens of millions of rupees.¹⁰¹ **Figure 4.1** based on latest available data on hospitalisation ratios show that female hospitalisation rates are consistently higher. In the context of various scams across states of large number of illegal hysterectomies being carried out on unsuspecting women, this may require focused attention. Hysterectomy costs are among the highest of all the procedures under RSBY, and this seems to be driving this phenomenon.¹⁰²

Existing evaluations show that RSBY implementation is riddled with concerns rooted in social inequalities. It was seen that districts with a higher share of socioeconomically backward castes are less likely to participate, and their enrolment rates are also lower. At the same time, districts with more non-poor households may be more likely to participate, even if their enrolment rates may still be low.¹⁰³ A study of RSBY in Gujarat showed no considerable difference between the OOP expenditure of insured and uninsured cohorts. Most of the health spending incurred by the patients covered by RSBY were related to medicines¹⁰⁴.

A recent study exploring the implementation of RSBY based on a large-scale multistage sample survey in Maharashtra (Ghosh, 2014) found that implementation of government insurance schemes through commercial insurance companies results in high administrative cost, large scale exclusions of eligible population and “supply-side moral hazards leading to draining out of precious public resources”. This study also found that only a small proportion of enrolled families had RSBY cards and only small proportion of enrolled families benefitted when they had to get admitted. The author observed further that “there is no country in the world which has engaged commercial insurance companies for implementing social health protection programmes”. The study recommended a reversal of healthcare financing mechanisms introduced in the last few years.¹⁰⁵

High hospitalisation ratios for women in RSBY are sometimes shown as instances of increased financial autonomy for women, sometimes by authors who have been closely involved with the implementation of the scheme.¹⁰⁶ However, increased access/utilisation cannot be read automatically as improved autonomy or empowerment. More so when, as part of RSBY, women become victims of corruption and unnecessary procedures are forced on them causing bodily harm.¹⁰⁷ In the light of the inconclusive and generally negative evidence, the high praise given to RSBY and other health insurance schemes by influential agencies including the World Bank Group and the International Labour Organisation (ILO) has contributed significantly to its policy popularity and as observed by a recent Oxfam paper, this is “both premature and dangerously misleading”.¹⁰⁸ Government of India’s Working Group on Health constituted for the Twelfth Five Year Plan in its report on the progress and Performance of NRHM specifically mentioned:

It is understood that in many states the RSBY has a poor claims ratio despite widespread moral hazards of overcharging, except in Kerala where the claims ratio is over 130%. It also has the propensity to convert primary and secondary care- into tertiary care and outpatient care into in-patient care. Mechanisms of gate-keeping or monitoring are weak and critical data needed for its evaluation is difficult to access. While recognizing the great hope and potential that lies behind this scheme, prudence calls for evaluation before this is scaled up even further- much less projected as the general solution. Publicly financed insurance programmes, when much better structured, monitored and regulated could play an important supplementary function, rather than become the main vehicle of health care financing.¹⁰⁹

It is clear from available evidence that there is no objective basis to any claim that insurance based models should be the vehicle for India’s efforts towards UHC. Despite their popularity at the highest levels of policymaking, it is observed that there is resistance to objectively evaluate government funded insurance schemes. Politicians and administrators often presume that independent evaluations cause more damage than benefit.¹¹⁰ State governments in India are known to be hesitant towards conducting independent evaluations of health insurance schemes, and RSBY, where it is often claimed that some “rigorous

assessment” of its impact is done, admittedly shares its scheme data “only with a carefully selected group of researchers”.¹¹¹

The National Medical Journal of India editorial in question made the previous observation four years ago, but unfortunately the situation has not changed. For RSBY, no disaggregated data on reimbursements-government money going to the private and public sectors -are available in the public domain. There seems to be no justification for not making public year-wise scheme information for up to the hospital level.

Interestingly, after it became a successful UHC case study, and a potential model to expedite India’s efforts towards healthcare for all, the RSBY data portal stopped uploading even the basic state level data, which was being infrequently updated earlier. The latest data available on the portal is from the first quarter of 2014. For many states like Bihar, latest data from many districts are from 2012.¹¹² The allegation that it is a private sector subsidy scheme still stands, particularly in the light of high prevalence of corruption and the limited, or even, negative impact that the scheme seems to have on OOP spending.

CHAPTER 5

WAY FORWARD

A cautious two-pronged approach of developing infrastructure through NRHM and providing gap-filling tertiary care through strictly regulated in-sourcing from the private sector may be inevitable in any effort towards UHC. As observed earlier, the historically underfunded, undersupplied and understaffed public sector- despite new investments in public primary care- is still trapped in the perceived image of lack of quality, and many outpatients are kept away from the public sector because of lack of coverage and shortages¹¹³. However, a systematic review which included India in its analysis rejected the claim that the private sector is more efficient, accountable, or medically effective than the public sector.¹¹⁴ The public sector seems to lack timeliness and hospitality towards patients, and it may be directly related to staff and infrastructure shortages.

The answer, however, does not seem to lie in the current insurance based models which in the name of bringing in 'competition' and 'efficiency', puts the public and private hospitals on an imaginary level playing field, and forces patients to vote with their feet in a situation of extreme information asymmetry. Substantially increased funding to directly address the shortfalls of physical infrastructure, healthcare personnel and availability of medicines are needed to regain people's faith in the public healthcare delivery system.

Complementing this, democratic relations both within public health delivery system and between people and the system will need to be deepened. Community based monitoring and participatory planning at the facility and community level becomes a must to make necessary improvements in public health facilities. An increase of public spending on health to 3% of GDP thus becomes a non-negotiable in the medium run.

Globally, the State is increasingly shifting from being a major provider of services to financier of select and limited set of needs for a minority within the poor. In India, the move towards an insurance based model is happening despite the flimsy evidence on which that choice is based. Although there is general acceptance for RSBY among policymakers as the model on which UHC in India should be based, it is not clear how serious issues like supplier induced demand, price discrimination (charging the insured more) and cost escalation that inflict RSBY in many states are going to be addressed while it is scaled up.

Nevertheless, it is often seen that when it comes to problem-solving, many policy-makers are informed and often driven by copious amounts of hope -much more than what robust health policy can possibly handle. For example, at the launch of RSBY in 2008, we had the bureaucrat in charge of the scheme writing

that the issue of fraud will be taken care of by the ‘competition’ between hospitals -- with poor patients identifying ‘rotten apples’ and approaching only the genuine providers.¹¹⁵

That we are talking about a sector with inherent information asymmetries adds to the irony of such thinking. The same bureaucrat wrote in 2011 in a laudatory United Nations Development Programme (UNDP) publication: “(RSBY) was perhaps the first-ever business model on this scale for a social-sector scheme with insurance companies and hospitals finding *fortune at the bottom of the pyramid* “. ¹¹⁶ Such blind enthusiasm cannot be the benchmark of healthy social policy. It is a matter of concern that after six years of operation, inconclusive findings, cases of corruption and financial irregularities in the scheme have not impacted RSBY’s policy popularity. However, there seems a slow reversal to the policy popularity to fortune-seeking models, as the Reserve Bank of India Governor sharply criticised micro-lenders for making a fortune out of the poor. He emphasised : “ one cannot, in good conscience, make a fortune at the bottom of the pyramid”¹¹⁷.

Another parallel case in point is the 5% service tax on centrally air-conditioned hospitals and diagnostic centres that was withdrawn as soon as it was proposed citing general resentment. This was attacked by industry giants as being a patently anti-*aam aadmi* measure. The obsession with *aam aadmi* was so much that in an open letter against the ‘misery’ tax, Dr Devi Shetty fumed; “Less than 10% of our population can afford heart, brain or cancer surgery. In the process we perhaps produce the largest number of young widows in the world”¹¹⁸. It was an unexceptionable demand, and the then minister took virtually no time in course-correction by withdrawing the ‘misery’ tax.

While the withdrawal of the tax in itself may not have been problematic, it carries a policy lesson on the attitude of the Indian State. In terms of the sheer scale of ‘misery’, it is the user fees in government facilities that would be causing more distress to the poor, both in terms of financial burden as well as in terms of forcing the poor to forgocare at all.¹¹⁹ Evidence has been there for almost twenty years and a policy consensus against the use of such fees in developing countries was reached many years ago.

Even after many poor African countries have successfully abolished user charges¹²⁰, India is yet to even start moving in that direction. Hence, we have a service tax that was removed in just a week of its introduction, while other service fees remains in operation for more than two decades. Common Review Missions of NRHM have criticised user fees year after year, but nothing has happened yet. It is a matter of concern that in the era of ‘evidence-based policymaking’, the State did not remove the service tax because of solid evidence against it, nor is it continuing with user fees for *lack of* solid evidence against it.

The main reason for the popularity of insurance-based solutions is their perfect harmony with policies of private-sector-led public health. For example, these are mostly agnostic about the nature of the providers -- making the scope for private ‘participation’ manifestly higher like in the case of RSBY where government shifts from being a provider of services to a financier. It is revealing that in a state like Maharashtra, which is perceived to have a large private health sector and a relatively better off public sector than many states, not even 1% of the hospitals empanelled for the scheme are from the public sector.

More important is the parallel development where the State is using strategies of privatisation, auctioning off and contracting out public healthcare facilities so as to minimise its own presence in the health sector. Driving people away from the public facilities has become almost a policy goal; nothing else can explain India choosing to retain user charges in its public hospitals ignoring evidence, even after most of Africa is moving towards its abolition. Seen in this context, while user charges push poor patients away from the public facilities, new insurance schemes offer incentives to access private facilities – both creating disincentives in the health systems in accessing public facilities. Without a doubt, this will get reflected in the next morbidity round of NSSO, and more evidence on how the poor prefer private sector will follow.

The section on healthcare financing in the initial draft of the Twelfth Plan Approach Paper started with the following befuddling statement, “public financing of health care does not necessarily mean provision of the service by public providers” and went on to recommend private sector participation through a government funded health insurance plan along the lines of RSBY¹²¹. In an environment of minimalist regulation, the patient is being transformed into a consumer. Even in states where the basic design of RSBY was improved substantially to enhance coverage and participation of public hospitals like in Kerala, concerns of moral hazard and cost escalation remain unaddressed.

Thankfully, there are other states that have experimented with inclusive innovations outside the insurance framework. Some such state level experiences with free access to medicine schemes will be explored in depth in a forthcoming Oxfam India publication. According to Xavier and Reddy (2014), Rajasthan, one of the least developed states in the country, is an example. It has been running a free medicines scheme since 2011. The state government spends \$50m a year to provide 400 types of free medicines to patients in government hospitals. Every day, some 200,000 people benefit from the scheme. The number of patients going to government hospitals for treatment in the state has increased by 56%. The Rajasthan experience also shows that medicines procured in bulk under their generic names cost far less. This disparity is possible because most of the medicines are not under any price control.¹²² In May 2015, Odisha has also launched its own free medicine scheme.¹²³

However, recent news suggests that the Rajasthan government has downsized the universal scheme, making it targeted.¹²⁴ The Central government had in fact promised in 2012 to provide free drugs in public health facilities. In 2014, there were plans to provide 348 essential drugs free of cost, which was later reduced to 50 drugs. The health ministry in April 2015 clarified that there will be no separate central scheme for free drugs and diagnostics¹²⁵.

The 2014-15 Union budget speech by Finance Minister Arun Jaitley promised a move towards health for all with schemes providing free drugs and diagnostics on a priority basis. However, there have been no financial provisions in the 2014-15 budget for either of these. Reports suggest that in the 2015-16 budget speech, the words medicine, drugs or diagnostics do not appear.¹²⁶ Thus, the withdrawal of the State from social sectors is happening at an accelerated pace, and a momentum towards insurance-based solutions in the health sector seems formidable at the moment.

In any effort towards UHC, increased outlays on health by the centre as well as the state governments is a non-negotiable. There has been marginal but consistent progress in this regard over the last decade. This has also been the result of the constant struggle by the civil society over past decades. If an insurance-based solution is opted for as part of the new UHC push, which would, in practical terms mean scaling up the untested RSBY, civil society activists will need to be vigilant that what happened with the NHS in the U.K. in 2000 does not happen.¹²⁷ It needs to be emphasised that any effort towards UHC that does not *discriminate* between private and public providers, will end up privileging the private sector in India, given the history of inadequate investments in the public sector, and given the extent of crony capitalist tendencies in the economy.

Alternative sources will have to be tapped in order to generate more resources for health. Calculating the costs of a wholly public owned network of providers and facilities, Duggal (2011) estimates Rs 3077 billion at 2009-10 prices for Universal Healthcare, which amounts to 4.73% of GDP. The public exchequer's share out of this will be about 3% of GDP, and the rest will be mostly from employers and employees in the organised sector, and other innovative mechanisms of financing.¹²⁸ As of now, there are serious inequities in the distribution of public spending among the population, which point towards the need to consolidate and merge the currently fragmented schemes. A review in 2015 showed that while RSBY that is a narrow scheme and covers 84 million individuals from the unorganised sector, the CGHS is a broad scheme that covers 3.2 million from the organised sector. The total spending – *not per capita* spending – on central

government employees through CGHS is more than eight times as compared to the spending on the BPL segment through RSBY.¹²⁹

Prats (2013) observes that India's tax-GDP ratio is just about half as that of Brazil or South Africa. Another key characteristic of the Indian tax system is the relatively low share of personal and corporate income taxes. In 2009-10, India's personal and corporate taxes were one of the lowest in all G20 countries, and well below South Africa and Russia. One reason for the shortfall is the low tax rate enjoyed by high earners. The current rate is even lower than the average maximum personal income tax rate in sub-Saharan Africa.¹³⁰ As for corporate income tax, research showed that there is a significant difference between the statutory tax rate (33 %) and the rate that is effectively being paid (24 %).¹³¹ Despite this, the Union budget for 2015-16 proposed to lower corporate taxes even further.¹³²

Abusive tax avoidance by Multi National Corporations (MNC) in India causes huge losses to exchequer every year. Recent research (Jansky and Prats, 2013) based on financial and ownership data of more than 1,500 MNCs operating in India showed that in 2010 those MNCs with links to tax havens reported 1.5 % less profits. These MNCs paid 17.4 % less in taxes per unit of asset and 30.3 % less in taxes per unit of profit than MNCs with no such links.¹³³

Studies indicate that India has the maximum number of transfer-mispricing cases in the world after Japan and Canada. According to the country's Directorate of Transfer Pricing, the amounts involved in mispricing ran at US\$12.6 billion in 2011-12. Corporation tax of 33 % on these amounts would have provided an additional US\$6.9 billion.¹³⁴ Despite having double tax avoidance agreements (DTAAs) with 88 countries¹³⁵, India still manages to lose a substantial chunk of potential tax revenue. Despite this alarming situation, general anti-avoidance rules (GAAR) have been deferred indefinitely, because it is feared to impact "investor confidence", both foreign and domestic.¹³⁶ A recent UN report calls for greater regional cooperation that can strengthen tax collection, enabling countries to avoid tax competition and to harmonise tax rates.¹³⁷

CBGA's analysis (CBGA, 2014) shows that the aggregate amount of revenue foregone due to exemptions in the central taxes is projected to be Rs. 5.73 lakh crore (equivalent to 5 % of GDP) for the year 2013-14.¹³⁸ All these point towards various possibilities to mobilise resources to cover increased health spending and improved financial protection. The financial protection that insurance schemes offer is at best, limited, as the main causes for OOP spending in India, namely out-patient care and drug spending, are left unaddressed by such schemes that the State promotes currently. Citing the case of Thailand, it was observed that including primary and preventive care as part of the insurance services, and providing them largely through the public sector facilities can significantly reduce moral hazard problems.¹³⁹

Focused funding to ensure that we have a working referral system – that is, there are restrictions on accessing secondary and tertiary healthcare without accessing primary care unless in emergency – can also be an effective check against spiralling medical costs.¹⁴⁰ However, health experts warn about the dangers of India moving towards a system of lightly-regulated health insurance coverage, as the task of regulating the system can be "beyond daunting", and it is far easier for the government to improve the functioning of health services that are directly under its control.¹⁴¹

The groundswell for UHC is very welcome (though already decades late), and at the same time challenging. UHC has the potential to transform the lives of millions of people by bringing life-saving healthcare to those who need it most.¹⁴² For the same reason, how we go about achieving UHC becomes extremely important.

POLICY RECOMMENDATIONS

- 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.
- 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.

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