

Financing healthcare in India - prospects for health insurance

Ravi Duggal

India is the most privatised health market in the world. Public support for healthcare has been historically low in India, averaging less than 1 per cent of the GDP, but what is worse is that in the last decade public health investment and expenditure has seen a secular declining trend.

During the same period the private health sector grew rapidly, from being about 3 per cent of GDP in the beginning of 1990s to over 5 per cent today. In fact, the health sector has been growing at the rate of 1.4 times that of the GDP. This also means that the burden out-of-pocket on households is also increasing rapidly and more so for the poorer sections, especially since the public health expenditures are declining.

What is worse is that the poor have to increasingly resort to taking debt or selling assets to meet costs of hospital care. It is estimated that 20 million people each year fall below the poverty line because of indebtedness due to healthcare. This is worrisome given the fact that more than two-thirds of the country's population is already either poor or living at subsistence levels.

The healthcare system

Public health facilities are allocated on the basis of population-based norms and/or on basis of specific geographic units. Thus for primary care, there are dispensaries and health centres which provide largely ambulatory care. Rural areas have mostly health centres like Primary Health Centres (PHCs) and sub centres through which preventive and promotive care is provided, largely through paramedics.

Taluka and other small towns usually have only dispensaries and a basic hospital. The district towns and larger towns and cities have dispensaries and one or more secondary level hospitals depending on their population size and these may be owned by either state and/or local governments; some of them may even have a teaching hospital and/or special hospitals. Compared to rural areas the urban areas are much better endowed with public health facilities.

Another special feature of public health services is that there are mass health care programmes, largely of a preventive and promotive nature, like selected disease control programmes, family planning and maternal and child health programs (contraception, immunisation, ante-natal care, etc). The public health system caters to 20 per cent of ambulatory care, 45 per cent of hospitalisations, 50 per cent of institutional deliveries, 65 per cent of antenatal care, 80 per cent of immunisations and 90 per cent of family planning services.

Private health care is much larger and more widespread than public health services. Individual practitioners in their clinics provide ambulatory care, which may often be

within their residence. The number of registered practitioners is estimated to be about 13 lakhs across the country with large concentrations in states like Maharashtra, Gujarat and the southern states, and about 80 per cent are in the private sector.

The allopathic doctors constitute about 45 percent of total registered practitioners and are located mostly in urban areas, whereas the non-allopaths are mostly located in the smaller towns and rural areas. With regard to private hospitals the data gaps are similar. There is no proper registration process for private hospitals and hence the data available is a gross underestimate, as revealed by surveys in Maharashtra and Andhra Pradesh.

The latest estimate reveals that nearly 70 per cent of all hospitals and 40 per cent of all hospital beds in the country are in the private sector with over 80 per cent of them being in urban areas. A peculiar characteristic of private health services is that, unlike the public health sector, they provide almost entirely only curative care. Further, the private health sector is fully commodified and totally unregulated with a complete absence of ethics in practice.

Financing healthcare

The total value of the health sector in India today is over Rs 1,500 billion or US\$ 34 billion. This works out to \$34 per capita which is 6 per cent of GDP. Of this 15 per cent is publicly financed, 4 per cent is from social insurance, 1 per cent private insurance and the remaining 80 per cent being out of pocket as user-fees (85 per cent of which goes to the private sector). Two thirds of the users are purely out-of-pocket users and 90 per cent of them are from the poorest sections.

The tragedy is that in India, as elsewhere, those who have the capacity to buy healthcare from the market most often get healthcare without having to pay for it directly, and those who are below the poverty line or living at subsistence levels are forced to make direct payments, often with a heavy burden of debt, to access healthcare from the market. National data reveals that 50 per cent of the bottom quintile sold assets or took loans to access hospital care.

Hence loans and sale of assets are estimated to contribute substantially to financing healthcare. This makes the need for insurance and social security even more imminent.

Public financing of healthcare comes largely from state government budgets, about 80 per cent, and the balance from the Union government (12 per cent) and local governments (8 per cent). Of the total public health budget today, about 10 per cent is externally financed in contrast to about 1 per cent prior to the structural adjustment loan from the World Bank and loans from other agencies.

Private financing is mostly out-of-pocket with a large proportion, especially for hospitalisations, coming not from current incomes but from savings, debt and sale of assets. Insurance contributions, whether for social insurance schemes or as private insurance premiums, constitute a very small proportion.

Social health insurance

The total employment in India today is estimated at 400 million but of this only 28 million is in what is called the organised sector, which is covered by comprehensive social security legislation, including social health insurance. The largest of this is the ESIS which covers 8 million employees, and including family members provides health security to 33 million persons. In 2002-03, the ESIS Corporation spent Rs 12 billion on healthcare for its member beneficiaries averaging Rs 365 per beneficiary. This effectively covers a mere 3.2 per cent of the population.

Another about half per cent of the population is covered through the CGHS. In the same year the CGHS spent Rs 2 billion averaging Rs 450 per beneficiary. While these social insurance plans have been around for a long time, their credibility is at stake and large scale out-sourcing to the private sector is taking place.

ESIS has private panel doctors in large cities who provide ambulatory care to those covered under ESIS whereas their own doctors in dispensaries and hospitals run by ESIS are increasingly idling. Similarly under CGHS, those covered are being given 'choice' to access private healthcare by being given reimbursements which for instance for a by-pass surgery could go upto Rs 150,000 for a senior bureaucrat.

Further, other government employees like the railways, defence services and the P&T department have significant healthcare services and/or reimbursements for their employees which amounts to a significant Rs 16 billion per annum and this averaged a whopping Rs 1,150 per beneficiary.

Also welfare funds have been created by Acts of parliament for specific occupational groups, including those in selected unorganised sector groups, like beedi workers, plantation workers, mine workers, building/construction workers, head load workers to meet social security benefits like healthcare, education, recreation, water supply, housing etc.

In 2002-03 these funds expended Rs 350 million on healthcare, which was about half the expenditure of the welfare funds. From rest of the organised sector, largely the middle and upper middle classes, about 30 million persons are provided healthcare protection from employers through reimbursements and/or employer provision.

This is estimated at about Rs 24 billion per year, averaging Rs 3000 per employee per annum. Thus about 10 percent of the country's population has some form of social insurance cover for health through their employment.

From time to time, the government has also introduced social security schemes, including health cover for various groups of population, especially the poor or below poverty line groups, in the unorganised sector, like the Krishi Shramik Samajik Sanstha Yojana, National Social Assistance Programme, National Family benefit scheme, National maternity benefit scheme, handloom workers thrift, health and group insurance,

agricultural workers central scheme, janashree bima yojana, state govt welfare funds, national illness assistance fund and state illness funds etc.

But these schemes are not run on a regular basis, that is if a person gets a benefit once there is no guarantee that the same person continues to get access to that scheme on a regular basis. No firm figures of their coverage are available because most such schemes, like the latest community health insurance scheme in the 2003-04 budget, are populist announcements to lend social credibility to the budget and when the next budget comes the scheme gets quietly archived.

Private health insurance

Private or what is often also called “voluntary” insurance is a recent phenomena starting in an organised way some time in the mid-eighties through the public sector insurance companies. Prior to that these insurance companies did have group insurance schemes for their special clients (read big general insurance clients) but that covered an insignificant number of employees and their families. From mid ‘80s, the mediclaim scheme which is an individual hospitalisation policy and does not cover comprehensive healthcare was started.

This picked up momentum gradually and entered the growth phase around 1998 but even today covers just over one percent of the population. The public sector insurance companies gross annual premiums of Rs 10 billion for mediclaim policies from 10 million insured lives. In the last few years, some private insurance companies have also entered the fray but they are as yet very small players having less than 10 per cent of the market share.

Insurance persons predict that mediclaim is slated to touch 50 million persons in the next two years with the rapidly escalating cost of private healthcare as also extension of user fees in public hospitals. The private insurance companies are also slated to capture an increased market share in this business.

Prospects for health insurance

The current political economy of healthcare in India makes India the most privatised health sector in the world. Out of pocket expenditures is the main mechanism of financing healthcare and in the context of large-scale poverty in India this not only contributes to widespread inequities but is also unsustainable. Public investments and expenditure on healthcare have been declining since India acquiesced to SAP.

The limited social insurance coverage, which exists mostly for the middle classes in India, is witnessing declining trends and also experiencing privatisation. World Bank and other multilateral and bilateral agencies are promoting private insurance as an option for classes who can afford to pay premiums and community finance strategies for the poor—they are advocating for a declining role of the state in public health finance.

This is contradictory to global experience which shows that universal access with equity can only be achieved with financing mechanisms which are largely of a public nature like social insurance, tax revenues, payroll deductions or some such combinations.

The phenomenal growth of the private health sector has also coincided with the decline and collapse of the public health sector during the same period. This is partly due to the worsening fiscal crises. In India Tax: GDP ratios are down to a mere 12 per cent as against most developed countries where such ratios are close to 30 per cent. With current fiscal policies directed at further reductions in tax revenues, the states' resource pool will shrink further and social expenditures like healthcare are the first to come under pressure.

What is worse is that the private health sector is completely unregulated, lacks any semblance of ethics in medical practice and no standards of care are followed. In such an environment health insurance does not stand a chance and it is precisely this factor that has prevented health insurance of any kind from playing any significant role in financing healthcare in the country.

Hence the little health insurance that exists in India, whether social or private, is restricted to classes who have the capacity anyway to buy the best healthcare from the market. And the poor and subsistence level populations who actually need the protection of insurance are burdened with out of pocket expenditures given the fact that public health services are not adequately accessible.

For health insurance to become a reality public finance has to take a dominant position for financing healthcare. For this to be made possible the entire health care system in the country, public and private, needs to be organised into a defined system which functions according to rules and regulations, uses standardised protocols for treatment and care, is subject to price regulation and is financed through pooling of all available resources under an independent and autonomous authority which is a public monopoly and accountable to all stakeholders.

To facilitate an organised and publicly financed healthcare system, a very large proportion of the work force will have to be included under a contributory scheme through the social insurance route. About half the country's population has the potential to be part of a social insurance mechanism.

The other half of the population can be supported through tax revenues and other publicly raised revenues, like sin taxes on alcohol, tobacco, paan masalas, private vehicles etc. The enhanced social insurance mechanism has the potential to raise an additional 2 per cent of the GDP for the public health sector. This is highly feasible in India but will need the appropriate political will to make it a reality.

To give health insurance and related financing mechanisms a chance appropriate legislation and a constitutional mandate, which brings healthcare into the social security ambit from a rights framework, will be necessary. For this to happen political will has to

be generated and for the latter civil society has to be activated to demand healthcare as a right.

Only such pressure from below will create the conditions for bringing in universal insurance for healthcare with equity. And under a universal healthcare system private health insurance will have a very limited role as is evident the world over in countries which are close to having universal access healthcare systems. Social insurance and tax revenues or some combination of it is the only sustainable mechanism for financing healthcare that is universally accessible with equity.

Email:raviduggal@vsnl.com